



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

June 23, 2006

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #84

The following acronyms are used in this transmittal:

- ADAPT – Application Benefit Delivery Automation Project
- ABD – Aged, Blind or Disabled
- AC – Aid Category
- CPU – Central Processing Unit
- CSRA – Community Spouse Resources Allowance
- DMHMRSAS – Department of Mental Health Mental Retardation and Substance Abuse Services
- DRA – Deficit Reduction Act of 2005
- DSS – Department of Social Services
- FAMIS – Family Access to Medical Insurance Security
- F&C – Families and Children
- FPL – Federal Poverty Level
- FPS – Family Planning Services
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- MMIS – Medicaid Management Information System
- MN – Medically Needy
- PD – Program Designation
- QDWI – Qualified Disabled and Working Individuals
- RR – Railroad Retirement
- SS – Social Security
- SSA – Social Security Administration
- SSI – Supplemental Security Income
- SSN – Social Security Number

The attached Medicaid Transmittal #84 contains new, updated, revised, and clarified policy as outlined below.

New policy

This transmittal contains the new policy required by the DRA of 2005, regarding the following eligibility requirements:

1. Verification of the citizenship and identity of all applicants and recipients, regardless of age, except for certain newborns born to Medicaid-enrolled mothers;
2. A life estate interest in real property counts as a resource to the applicant or recipient unless the life estate interest is in property that serves as the individual's principal place of residence;
3. An individual's entrance fee in a continuing care retirement community or life care community that collects an entrance fee upon admission may be a countable resource in some circumstances;
4. For Medicaid payment of LTC, substantial home equity, defined as equity in home property that exceeds \$500,000, will make the home owner ineligible for Medicaid payment of LTC services, unless the home is occupied by a spouse, dependent child under age 21, or a blind or disabled child of any age;
5. For Medicaid payment of LTC, the asset transfer policy has changed for transfers made on or after February 8, 2006. The following asset transfer policies are changed for these transfers:
 - a. Look-back date and period;
 - b. Begin date of the penalty period for LTC payments;
 - c. Penalty period calculation;
 - d. Undue hardship for uncompensated asset transfer;
 - e. Annuities established on or after February 8, 2006;
 - f. Promissory notes, loans or mortgages established on or after February 8, 2006.

Updates to policy

This transmittal contains the July 1, 2006, increases in the LIFC 185%, F&C and MN income limits, and the increased Community Spouse Monthly Maintenance Needs Standard and Excess Shelter Allowance for married institutionalized individuals that are effective July 1, 2006. The income limits will be updated in ADAPT. If a renewal for a married institutionalized individual with a community spouse is processed on or after July 1, 2006, and the change in the standards decreases the patient pay amount, adjust the patient pay to reflect any overpayments using the procedures in M1470.900 C.1.

Clarifications of policy

This transmittal includes clarifications of the following policy: the exemption of the SSN requirement for illegal or undocumented aliens only; the criteria for granting the student earned income exclusion; treatment of resources for an SSI recipient; resource assessment and CSRA policy and examples; and the procedures for transferring cases between the LDSS and FAMIS CPU, which was contained in Broadcast #3690.

Effective date

The new policy is effective for all eligibility determinations started or completed on or after July 1, 2006. It is applicable to applications and renewals processed on or after July 1, 2006, regardless of application date. Do not review any applications or renewals processed and completed before

July 1, 2006 for the new policy unless a change is reported in the case before the next scheduled renewal.

The policy clarifications, revisions and updates contained in this transmittal are effective for all eligibility determinations completed on or after July 1, 2006.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0110 pages 1-4	Subchapter M0110 pages 1-4a	Page 1 is a reprint. On pages 2 and 3, clarified release of information policy. On pages 4 and 4a, revised section lettering.
Subchapter M0130 pages 3-6	Subchapter M0130 pages 3-6	Page 3 is a reprint. On page 4, removed citizenship for children under age 19 from the list of eligibility requirements that do not require verification. On page 5, added citizenship and identity to the list of requirements that require verification, and clarified illegal aliens not required to provide or apply for an SSN. Page 6 is a runover page.
Subchapter M0220 Table of Contents pages 1-4	Subchapter M0220 Table of Contents pages 1-4j Appendix 7 Appendix 8 Appendix 9 Appendix 10	Updated the Table of Contents. Page 1 is a reprint. On pages 2-4h, added new policy regarding verification of citizenship and identity of all Medicaid applicants and recipients except newborns. Pages 4i and 4j are runover pages. Added Appendices 7, 8 and 9, containing the new affidavits. Added Appendix 10, contact information for citizenship and identity documents.
Subchapter M0310 pages 11, 12	Subchapter M0310 pages 11, 12	Page 11 is reprinted. On page 12, added a note to the dependent child definition that the school enrollment policy does not apply to deciding the student earned income exclusion.
Subchapter M0320 pages 19, 20 pages 23, 24 pages 50a-50c	Subchapter M0320 pages 19, 20 pages 23, 24 pages 50a-50c	On page 19, clarified text. Pages 19 and 23 are reprinted. On pages 20 and 24, clarified when a QSII or SSI recipient does not have a type

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		of listed real property resource, resources are not evaluated. On page 50a, clarified that pregnant women are eligible for FPS for 12 months from the end of pregnancy, regardless of income changes, and that their eligibility must be redetermined at 12 months. Page 50b is a runover page. On page 50c, changed “PD” to AC” and updated the AC codes.
Subchapter M0710 Appendix 1 Appendix 3, pages 1, 2 Appendix 5	Subchapter M0710 Appendix 1 Appendix 3, pages 1, 2 Appendix 5	Updated the LIFC 185% income limit in Appendix 1. Updated the F&C income limits on pages 1 and 2 in Appendix 3. Updated the MN income limits in Appendix 5.
Subchapter M0720 pages 11, 12	Subchapter M0720 pages 11, 12	On pages 11 and 12, clarified the student earned income exclusion by defining who is a student.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	Page 1 is reprinted. On page 2, updated the MN income limits.
Subchapter M0830 pages 27, 28	Subchapter M0830 pages 27, 28	On pages 27 and 28, clarified when RR benefits are SSA Title II benefits and how to verify them.
Subchapter M1110 pages 13-16	Subchapter M1110 pages 13-16	Pages 13 and 16 are reprints. On page 14, added new policy: life estate in real property is not counted as a resource when the property serves as the principle place of residence. Life rights to real property are a countable resource when the property no longer serves as the individual’s place of residence. On page 15, corrected the manual reference in item C.3.
Subchapter S1120 Table of Contents page 29	Subchapter S1120 Table of Contents page 29	Updated the Table of Contents. On page 29, added policy clarifying the treatment of reverse mortgages.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S1130 pages 23, 24	Subchapter S1130 pages 23, 24	Page 23 is a reprint. On page 24, clarified how burial space items are evaluated.
Subchapter S1140 Table of Contents pages 5, 6 pages 11, 12 pages 25-28	Subchapter S1140 Table of Contents pages 5, 6 pages 11, 12 pages 25-28	Updated the Table of Contents. Pages 5, 25 and 28 are reprints. On page 6, corrected the reference to the Appendix in item C.1. On pages 11 and 12, added the new life estate policy for all ABD covered groups except QDWI. On page 26, clarified policy for annuities. On pages 26a and 26b, clarified promissory note, loan or mortgage policy. On page 27, added new policy section about the treatment of continuing-care or life-care retirement community entrance fees.
Chapter M14 Table of Contents	Chapter M14 Table of Contents	Updated the Table of Contents for Chapter M14.
Subchapter M1440 pages 13, 14	Subchapter M1440 pages 13, 14	On page 13, added several covered services to the list of services available under the Mental Retardation Waiver. Page 14 is a reprint.
Subchapter M1450 Table of Contents pages 1-46	Subchapter M1450 Table of Contents pages 1-40 Appendix 1 Appendix 2 Appendix 3	Updated the Table of Contents; renumbered most sections, added new sections. On page 1, added DRA 2005 to the legal base. On page 2, added life rights in another person's home and funds used to purchase a promissory note, loan, or mortgage, to the asset definition. On page 3, changed a section number in a reference. On page 4, clarified the institutionalized individual definition and designated sections within the "look-back" date definition. On page 5, added new policy to the look-back and

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Significant Changes

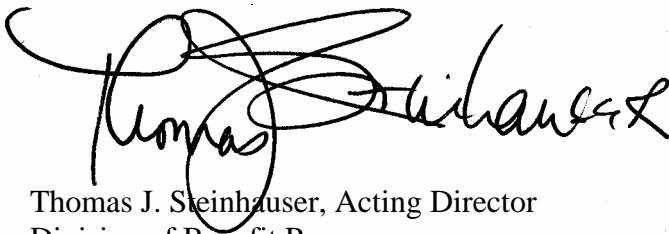
look-back period definitions. On page 6, added an explanation of the organization of the remaining subchapter, added a procedure for transfers that occurred prior to August 11, 1993, and redesignated reference section numbers. On page 7, renumbered and renamed the section to reflect the new policy for transfers that occurred on or after February 8, 2006. On page 8, added the new section for transfers that occurred on or after February 8, 2006. Page 9 is a runover page. On page 10, changed the number of months retroactive SSI and SS payments are not considered assets. Pages 11 and 12 are runover pages. On pages 13 and 14, changed reference section numbers. On page 15, added new policy regarding transfers into annuities, and transfers made on or after February 8, 2006 with cumulative value less than or equal to \$4,000. On page 16, changed section references. On page 17, changed a section number and title. On page 18, clarified that the annuity policy in the section applies only to annuities purchased before February 8, 2006. On page 19, added new policy section about purchase of an annuity on or after February 8, 2006. On page 20, added new policy section for purchase of promissory note, loan or mortgage on or after February 8, 2006. Pages 21, 22 and 23 are runover pages. On pages 24 and 25, added new section and new policy for undue hardship claim. Pages 26 through 28 are runover pages. On page 29, changed section reference. On page 30, renamed and renumbered section.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		<p>On page 31, changed a section reference. Pages 31 and 33 are runover pages. On page 32, changed dates in the example. On pages 34 and 35, renumbered reference sections in the examples. On pages 36 and 37, added new policy and section for the penalty period for transfers on or after February 8, 2006. Renumbered the sections on pages 38-40. Appendices 1, 2, and 3 added to the subchapter.</p>
<p>Subchapter M1460 Table of Contents pages 3-8</p>	<p>Subchapter M1460 Table of Contents pages 3-8a</p>	<p>Updated the Table of Contents. On pages 3 and 4, added new policy regarding substantial home equity that precludes eligibility for Medicaid payment of long-term care. Pages 5 and 6 are runover pages. On page 7, clarified entitlement to SSI. On page 8, clarified that when an SSI recipient does not have a type of listed real property resource, do not evaluate the recipient's resources. Page 8a is a runover page.</p>
<p>Subchapter M1480 Table of Contents pages 7-10 pages 13-16 pages 17-50a pages 65-68</p>	<p>Subchapter M1480 Table of Contents pages 7-10 pages 13-16 pages 17-50b pages 65-68</p>	<p>Updated the Table of Contents. On pages 7 and 8, added the new policy for substantial home equity precluding eligibility for Medicaid payment of LTC. Pages 8a , 8b and 10 are runover pages. On pages 9 and 13, clarified the resource policy to use in resource assessments. On page 14, clarified resources as of the first moment of the first day of the application month and retroactive months being determined. Pages 15 and 16 are runover pages. On page 17, clarified resources counted in determining the institutionalized spouse's resource eligibility. On</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		<p>pages 18-29, clarified the procedures and examples for determining initial resource eligibility. On pages 30-35, clarified the calculation of the CSRA. Pages 36 and 37 are runover pages. On pages 38-43, the CSRA examples are clarified. Page 44 is a runover page. On pages 45 and 46, clarified the example. Pages 47-50 are runover pages. On pages 50a and 50b, changed “PD” to “AC” and updated the AC codes. Page 65 is a reprint. On page 66, updated the monthly maintenance needs standard and the excess shelter standard. On page 67, corrected a section reference. Page 68 is a reprint.</p>
<p>Subchapter M1520 pages 5-8</p>	<p>Subchapter M1520 pages 5-8</p>	<p>Pages 5 and 8 are reprinted. On page 6, clarified the review requirements for an FPS enrollee. Page 7 is a runover page.</p>
<p>Subchapter 1550 Table of Contents pages 1-10</p>	<p>Subchapter 1550 Table of Contents pages 1-10 Appendix 1</p>	<p>Updated the Table of Contents. Updated the information and clarified policy and procedures for the DMHMRSAS Medicaid Technicians on pages 1-10. Added Appendix 1, the list of the Medicaid Technicians and the Supervisor located in DMHMRSAS facilities.</p>
<p>Chapter M18 pages 3, 4</p>	<p>Chapter M18 pages 3, 4</p>	<p>Page 3 is a reprint. On page 4, deleted the ABD 80% FPL covered group from the list of Medicaid enrollees who are exempted from managed care. ABD 80% FPL enrollees are required to be in managed care.</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M21 Table of Contents pages 1-4 pages 9-11	Chapter M21 Table of Contents pages 1-4 pages 9-14	Updated the Table of Contents. Page 1 is a reprint. On pages 2 and 3, clarified that Cuban-Haitian Entrants are qualified aliens and can be eligible for FAMIS, regardless of date of entry in U.S. Page 4 is a reprint. Page 9 is a reprint. On pages 10-14, added the LDSS-CPU-FAMIS Plus Unit procedures from Broadcast #3690.
Chapter M22 page 9	Chapter M22 page 9	On page 9, added references to section M2140.100 for procedures to use when transferring a FAMIS MOMS case to the CPU, and for policy and procedures to use when an enrollee transitions between Medicaid and FAMIS MOMS.

Please retain this transmittal letter in the back of Volume XIII.



Thomas J. Steinhauser, Acting Director
Division of Benefit Programs

Attachment

M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the Medicaid program and be conducted in a manner which respects the personal dignity and privacy of the individual.

B. Legal Base

The Medical Assistance Program (Medicaid) is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia.

Virginia law provides that the Medicaid program be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1.DMAS

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- the handling of appeals related to medical assistance,

- the approval of providers authorized to provide medical care and receive payments under Medicaid,
- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

3. Confidentiality

Medicaid applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

a. Release of Client Information

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

b. Release of Information to Medical Providers

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Medicaid providers by DMAS or DSS without the applicant's/enrollee's consent. Enrollee consent is not needed for the agency to provide an updated DMAS-122 to a Medicaid provider or to provide confirmation

*of an individual's eligibility, the dates of eligibility, and any patient pay responsibility. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources without a release of information because the provider does not need that information for medical treatment or payment.*

*Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Provider contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record without the person's release of information.*

Local agencies may release Medicaid enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is *being released* to an identifiable provider.

c. Release to Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

d. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

***e.* Ownership of Records**

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

***f.* Release of Client Information with Consent**

As part of the application process for Medicaid, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in 3.a above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

***g.* Release of Client Information without Consent**

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, Immigration and Naturalization Services (INS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with INS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

***h.* Client's Right of Access to Information**

(1) Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality.

**4. Time Standard
Exceptions**

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

**C. Application for
Retroactive
Coverage**

When an applicant for Medicaid reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application, retroactive Medicaid eligibility must be determined. The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see M1510, Appendix 1).

Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number or application for the number, and date of birth.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.

C. Verification of Nonfinancial Eligibility Requirements

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- Virginia state residency,
- application for other benefits,
- institutional status,
- age for children under age 19,
- Social Security number (see section D below),
- health insurance information (see sections E and F below), and
- dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.

The following information must be verified:

- *identity and citizenship;*
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older;
- disability and blindness; and
- pregnancy.

See item E. below for instructions on the verification of legal presence. *See subchapter M0220 for instructions on the verification of identity and citizenship.* See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

If an SSN has not been issued, the applicant must cooperate in applying for such a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not born to a Medicaid-eligible woman, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

Exceptions:

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together. A child eligible in this category does not need a Social Security number.
- *Illegal* aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for**

Medicaid payment for emergency services are not subject to the legal presence requirement. An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

**1. Documents
That
Demonstrate
Legal Presence**

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**2. Failure to
Provide Proof
of Legal
Presence**

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is in Appendix 2 to this subchapter. NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**3. Relationship to
Other Medicaid
Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.

**F. Third Party
Liability (TPL)**

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must forward the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS**M0220.001 GENERAL PRINCIPLES****A. Introduction**

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the U.S.. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a “qualified” alien and the alien’s date of entry into the U.S.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), effective on July 1, 1997, explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). It contains the entitlement and enrollment procedures for full benefit aliens and emergency services aliens who meet all other Medicaid eligibility requirements.

**B. Declaration of
Citizenship/Alien
Status**

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. *The declaration statement is on the application form.*

EXCEPTION: An individual who is an “unqualified” alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

C. Procedures

The policy and procedures for determining whether an individual is a citizen or a “full benefit” or an “emergency services” alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status;
M0220.300 Full Benefit Aliens;
M0220.400 Emergency Services Aliens;
M0220.500 Aliens Eligibility Requirements;
M0220.600 Full Benefit Aliens Entitlement & Enrollment;
M0220.700 Emergency Services Aliens Entitlement & Enrollment.

M0220.100 CITIZENSHIP AND NATURALIZATION**A. Introduction**

A citizen or naturalized citizen of the U.S. meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

The Deficit Reduction Act (DRA) of 2005 requires that effective July 1, 2006, all Medicaid applicants and enrollees who declared citizenship at the time of application, or for whom citizenship was declared at the time of application, present satisfactory evidence of citizenship and identity.

EXCEPTION: this policy does not apply to newborns who meet the Medically Indigent (MI) Newborn children in section M0320.301, or Medically Needy (MN) Newborn Children in section M0320.302, covered groups because a Medicaid application is not required for these newborns.

Title IV-E children who apply for or receive Medicaid must have in their case record a declaration of citizenship or qualified immigration status AND documentary evidence of the children's citizenship or declared qualified immigration status. Title IV-E eligible children do NOT have to verify identity.

B. Procedures**1. Individual Born in the U.S.**

An individual born in the United States, any of its territories (Guam, Puerto Rico, U.S. Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a U.S. citizen.

NOTE: A child born in the U.S. to non-citizen parents who are in the U.S. as employees of a foreign country's government may not meet the U.S. citizen requirement. When a child born in the U.S. to non-citizen parents is a U.S. citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the U.S.

2. Individual Born Outside the U.S.**a. Individual Born to or Adopted by U.S. Citizen Parents**

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.

b. Individual Born to Naturalized Parents

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

c. Naturalized Individual

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above, must have been naturalized to be considered a citizen.

**3. Verification
Required**

At the time of application, the applicant must be given a reasonable opportunity to present documents establishing U.S. citizenship and identity. An individual who is active in Medicaid and who was enrolled in Medicaid prior to July 1, 2006, must present documentation of his citizenship and identity at the time of the first redetermination of eligibility occurring on or after July 1, 2006. Once documentation has been provided and recorded in the case record, it is not necessary to obtain documentation again. Documentary evidence may be accepted without requiring the applicant or recipient to appear in person.

**C. Documents
Establishing U.S.
Citizenship and
Identity****a. Citizenship Document**

To establish U.S. citizenship, the document must show:

- *a U.S. place of birth, or*
- *that the person is a U.S. citizen.*

NOTE: Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens.

NOTE: A state driver's license issued by any state or territory, including Virginia, does NOT prove citizenship. It will satisfy requirements for proof of identity if the license has either a photograph of the individual or other identifying information about the individual such as name, age, sex, race, height, weight or eye color.

b. Identity Document

To establish identity a document must show:

- *evidence that provides identifying information that relates to the person named on the document.*

c. Acceptable Documents

*All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies **are not** acceptable.*

d. Charts of Acceptable Documents

The following charts in subsections 1-5, below, list acceptable evidence of U.S. citizenship and/or identity. Charts 1-4 address citizenship and Charts 1 and 5 address identity.

If an individual presents documents from Chart 1, no other information is required. If an individual presents documents from Charts 2-4, then an identity document from Chart 5 must also be presented. Charts 1-4 establish a hierarchy of reliability of citizenship documents. The following instructions specify when a document of lesser reliability may be accepted by the agency.

An asterisk by the document in the charts means that the document is listed in the law, section 6036 of DRA 2005 (public law No. 109-171).

*See **subsection 6** for documents that prove citizenship by collective naturalization.*

See M0220, Appendix 10 for information about the documents, the document issuer, and contact information for each document.

e. How to Verify Citizenship and Identity

First, ask the individual if he has a document listed in Chart 1 – U.S. Passport, Certificate of Naturalization or a Certificate of Citizenship. If the individual presents the original of one of these documents, he has verified his citizenship and identity.

f. How to Verify Citizenship

If the individual does not have one of the documents in Chart 1, ask if he has one of the documents in Chart 2 to prove citizenship. If the individual presents the original of one of the documents in Chart 2, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the documents in Chart 2, ask if he has one of the documents in Chart 3 to prove citizenship. If the individual presents the original of one of the documents in Chart 3, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the documents in Chart 3, ask if he has one of the documents in Chart 4 to prove citizenship, which includes a written affidavit. If the individual presents the original of one of the documents in Chart 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not present one of the documents in Chart 4 to verify citizenship, he is not eligible for Medicaid because he has failed to provide documentary evidence of citizenship.

g. How to Verify Identity

If the individual presents the original of one of the documents in Chart 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity, which includes a written affidavit for a child under age 16. M0220, Appendix 9 contains the Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16.

NOTE: *An affidavit of identity for a child under 16 cannot be used if an affidavit was used to verify the child's citizenship. An affidavit of identity cannot be used for an individual age 16 or older.*

If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity.

**1. CHART 1 –
Primary
Documents to
Establish Both
U.S.
Citizenship and
Identity**

Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. Obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in Chart 1 as primary evidence of both U.S. citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

NOTE: Persons born in American Samoa (including Swain's Island) are generally U.S. non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by U.S. Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

Applicants or recipients born outside the U.S. who were not citizens at birth must submit a document listed under primary evidence of U.S. citizenship.

CHART 1

Primary Documents	Explanation – Chart 1
* U.S. Passport	<p><i>The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation.</i></p> <p><i>Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</i></p> <p><i>Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</i></p>
* Certificate of Naturalization (N-550 or N-570)	<i>Department of Homeland Security issues this document for naturalization.</i>
* Certificate of Citizenship (N-560 or N-561)	<i>Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</i>

**2. CHART 2 –
Secondary
Documents to
Establish U.S.
Citizenship**

*Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. A second document establishing identity **MUST also be presented** (see Chart 5, Evidence of Identity). Available evidence is evidence that exists and can be obtained within the application processing time frame (see section M0130.100).*

Accept any of the documents listed in Chart 2 as secondary evidence of U.S. citizenship if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

NOTE: Applicants or recipients born outside the U.S. must submit a document listed under **primary evidence** of U.S. citizenship.

CHART 2

Secondary Documents	Explanation – Chart 2
<p>A U.S. public birth record showing birth in:</p> <ul style="list-style-type: none"> • one of the 50 U.S. States; • District of Columbia; • American Samoa; • Swain's Island *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time)); or • Guam (on or after April 10, 1899) 	<p>The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age.</p> <p>An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.</p> <p>Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. *See additional requirements for Collective Naturalization.</p>
*Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
*Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
*Certification of Birth Abroad (FS-545)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

Secondary Documents	Explanation – Chart 2
<i>United States Citizen Identification Card (I-197) or the prior version I-179 (Section 6036 referred to these documents in error as an I-97)</i>	<i>INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.</i>
<i>American Indian Card (I-872)</i>	<i>DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.</i>
<i>Northern Mariana Card (I-873)</i>	<i>The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.</i>
<i>Final adoption decree</i>	<i>The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.</i>
<i>Evidence of civil service employment by the U.S. government</i>	<i>The document must show employment by the U.S. government before June 1, 1976.</i>
<i>Official Military record of service</i>	<i>The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).</i>

**3. CHART 3 –
Third Level
Documents to
Establish U.S.
Citizenship**

Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used ONLY when the following conditions exist:

- primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below),*
- secondary evidence does not exist or cannot be obtained, **and***
- the applicant or recipient alleges being born in the U.S.*

In addition, a second document establishing identity MUST be presented as described in Chart 5, "Evidence of Identity."

Accept any of the documents listed in Chart 3 as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree.

CHART 3

Third Level Documents	Explanation – Chart 3
Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth.	Do not accept a birth certificate "souvenir" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.
Life or health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial Medicaid application date.	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

**4. CHART 4 -
Fourth Level
Documents**

Fourth level evidence should **ONLY** be used in the rarest of circumstances. This level of evidence is used **ONLY** when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity **MUST** be presented as described in Chart 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Accept any of the documents listed in Chart 4 as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship). A second document establishing identity must be presented.

Fourth level evidence, as described in Chart 4 below, consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. **The written affidavit described in Chart 4 may be used only when the State is unable to secure evidence of citizenship listed in any other Chart.**

CHART 4

<i>Fourth Level Documents</i>	<i>Explanation – Chart 4</i>
<i>Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950).</i>	<p><i>The census record must also show the applicant's age.</i></p> <p><i>NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or agency should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Add that the purpose is for Medicaid eligibility. This form requires a fee.</i></p>
<i>Other document as listed in the explanation that was created at least 5 years before the application for Medicaid.</i>	<p><i>This document must be one of the following and show a U.S. place of birth:</i></p> <ul style="list-style-type: none"> • <i>Seneca Indian tribal census record,</i> • <i>Bureau of Indian Affairs tribal census records of the Navaho Indians,</i> • <i>U.S. State Vital Statistics official notification of birth registration,</i> • <i>An amended U.S. public birth record that is amended more than 5 years after the person's birth, or</i> • <i>Statement signed by the physician or midwife who was in attendance at the time of birth.</i>
<i>Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth.</i>	<i>Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</i>
<i>Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth.</i>	<p><i>Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</i></p> <p><i>Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.</i></p> <p><i>Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application.</i></p>
<i>Written affidavit of citizenship</i>	<i>Affidavits should ONLY be used in rare circumstances. An affidavit must be by at least two individuals, of whom one is not related to the applicant/recipient, who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. The person(s) making the affidavit must be able to provide proof of his/her own citizenship and identity for the affidavit to be accepted.</i>

<i>Fourth Level Documents</i>	<i>Explanation – Chart 4</i>
	<i>If the affiant has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well. It must be signed under penalty of perjury by the person making the affidavit. M0220, Appendix 7 contains the Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients. A second affidavit from the applicant/recipient or other knowledgeable individual must also be provided explaining why documentary evidence does not exist or cannot be readily obtained. M0220, Appendix 8 contains the Affidavit of Citizenship By Medicaid Applicants and Recipients.</i>

**5. CHART 5 -
Evidence of
Identity**

Section 1903 provides that identity must be established. When primary evidence of citizenship described in Chart 1 above is not available, a document from the lists in number 2 through 4 may be presented if accompanied by an identity document from this list in Chart 5.

CHART 5

<i>Documents</i>	<i>Explanation – Chart 5</i>
<i>Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.</i>	<i>Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.</i>
<i>Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.</i>	<p><i>Use 8 CFR 274a.2(b)(1)(v)(B)(1). This section includes the following acceptable documents for Medicaid purposes</i></p> <ul style="list-style-type: none"> • <i>driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color;</i> • <i>School identification card with a photograph of the individual;</i> • <i>U.S. military card or draft record</i> • <i>Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;</i> • <i>Military dependent's identification card;</i> • <i>Native American Tribal document;</i> • <i>U.S. Coast Guard Merchant Mariner card.</i> <p><i>Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1).</i></p> <p><i>NOTE: For children under 16, school records may include nursery or child care records.</i></p>
<i>For children under age 16, written affidavit of identity.</i>	<i>For children under 16, if none of the above documents in Chart 5 are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided for the child. M0220, Appendix 9 contains the Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16.</i>

**6. Collective
Naturalization**

The following will establish U.S. citizenship for collectively naturalized individuals:

a. Puerto Rico:

- 1) *Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or*
- 2) *Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.*

b. U.S. Virgin Islands:

- 1) *Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927;*
- 2) *The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or*
- 3) *Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.*

c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- 1) *Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);*
- 2) *Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or*
- 3) *Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).*

NOTE: *If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.*

D. Agency Action**1. Individual NOT Required to Submit Documents in Person**

*Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."*

2. SSI Recipients

Use SVES to verify the citizenship status of an SSI recipient. An SSI recipient's citizenship status can be found on page 8 of the SVES inquiry response, in the Alien Indicator Code field. Code "A" means "proven U.S. born U.S. citizen;" code "C" means "U.S. Citizen born outside U.S."

3. Reasonable Opportunity to Verify Citizenship and Identity

The agency must give an applicant or recipient who claims to be a citizen a reasonable opportunity to present documents establishing U.S. citizenship or nationality and identity. For individuals who are already Medicaid recipients, such individuals remain eligible until determined ineligible as required by Federal regulations. A determination terminating eligibility may be made only after the recipient has been given a reasonable opportunity to present evidence of citizenship or the agency determines the individual has not made a good faith effort to present satisfactory documentary evidence of citizenship.

By contrast, applicants for Medicaid (who are not currently receiving Medicaid), should not be determined eligible until they have presented the required verification.

The "reasonable opportunity period" must be consistent with the timely processing policy requirements so that the agency does not exceed the limits established for timely determination of eligibility. The processing time limits are:

- 10 working days from the date of receipt for applications submitted by pregnant women and women in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;*
- 45 calendar days from the date of receipt for other applications that do not involve a disability determination; and*
- 90 calendar days from the date of receipt for applications that require a disability determination.*

The policy permits exceptions from these time limits when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the agency should extend the application processing time limit and assist the individual in securing evidence of citizenship and/or identity. "Assisting" the individual means that the agency MAY choose to pay the fee for the individual to obtain a required document, but the agency is not required to do so.

If the individual, legal guardian, or other responsible party indicates that additional time is required, allow a reasonable amount of additional time based on the type of documentation being sought. Failure to provide

satisfactory evidence of citizenship and identity, after being provided a reasonable time to present such documentation, must result in the denial or termination of Medicaid.

4. Failure to Provide Requested Verifications

An applicant or recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant, recipient or that individual's representative, after being notified, to take a required action within the specified time period.

5. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

6. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

7. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the USCIS and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.

If the alien

- has an alien number but no USCIS document, or
- has no alien number and no USCIS document,

use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Form I-151 (Alien Registration Receipt Card – the old “green card”), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). An alien with one of the older cards who does not have an I-551 should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the local USCIS office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some USCIS offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an USCIS form. If there is any question as to the veracity or status of the document, contact USCIS.

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his/her immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he/she provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients

The Deficit Reduction Act of 2005 requires proof of citizenship and identity for Medicaid applicants and recipients. This affidavit may be used to establish a claim of citizenship when the acceptable documentation of citizenship is not available and cannot be obtained in a reasonable period of time. **I understand that as the signer of this affidavit, I must provide proof of my own citizenship and identity for the affidavit to be valid.** The Department of Social Services may request additional information regarding the information if needed.

If an affidavit is used to establish a claim of citizenship for a child under age 16, an affidavit cannot be used to establish the child's identity.

I _____ (name) know that _____ (name of Medicaid applicant/recipient) is a citizen of the United States and was born on _____ (date of birth) in _____ (place of birth). I have knowledge of this information because

_____.

I know that _____ (name of Medicaid applicant/recipient) cannot provide proof of citizenship because _____

_____.

I hereby certify, under penalty of perjury, that I am a U.S. citizen and that the information that I have provided is true and correct to the best of my knowledge and belief.

Signature of *Person Making This Affidavit*

Date

Relationship to Applicant/Recipient

Agency Use Only

Worker _____

Citizenship documentation

Type _____

Identity documentation

Type _____

Affidavit of Citizenship By Medicaid Applicants and Recipients

The Deficit Reduction Act of 2005 requires proof of citizenship and identity for Medicaid applicants and recipients. This affidavit may be used to establish a claim of citizenship when the acceptable documentation of citizenship is not available and cannot be obtained in a reasonable period of time. The Department of Social Services may request additional information if needed.

I, _____ (name) am a citizen of the United States. I do not have verification of citizenship such as a passport, birth certificate, final adoption decree, military record of service, etc. and am unable to provide this documentation because:

_____.

I, _____, was born on _____

Name at birth

Date

in _____

Place of birth

If my current name is different from my name at birth it is because: _____

I hereby certify, under penalty of perjury, that the information above is true and correct to the best of my knowledge and belief.

Signature of Applicant/Recipient/Authorized Representative

Date

Affidavit of Identity For Medicaid Applicants and Recipients Under Age 16

The Deficit Reduction Act of 2005 requires proof of citizenship and identity for Medicaid applicants and recipients. This affidavit may be used to establish a claim of identity for a child under the age of 16 when acceptable documentation of identity is not available and cannot be obtained in a reasonable period of time. The Department of Social Services may request additional information if needed.

If an affidavit is used to establish a claim of identity for a child under age 16, an affidavit cannot be used to establish the child's citizenship.

I _____ (name) have been informed of the requirement to provide proof of identity for the children listed below. I do not have proof of identity, such as, a driver's license, school identification card, school records or child care records for my children. I am unable to provide this documentation because:

_____.

Name of child

Relationship to Child

Date of birth

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify, under penalty of perjury, that the information above is true and correct to the best of my knowledge and belief.

Signature of Parent/Guardian

Date

Proof of U.S. Citizenship and Identity for Medicaid

Effective July 1, 2006, individuals who declare on a Medicaid application that they are United States citizens must provide proof of citizenship and identity. Individuals who are already enrolled in Medicaid must provide this documentation at the time of their next Medicaid renewal.

Some common documents that may be used to meet the citizenship and identity requirement are listed below. Representatives from your local department of social services can tell you what other documents may be acceptable. If you have difficulty obtaining one of the documents listed or have any questions, please discuss your situation with your eligibility worker. Whenever possible, we will allow additional time for you to obtain the necessary documentation.

The following documents are proof of both citizenship and identity; no additional documents are necessary to meet the Medicaid requirement to provide proof of citizenship and identity.				
Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Passport (unexpired or expired)	Citizenship & Identity (if issued with limitation and expired, only shows proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
Certificate of Naturalization (N-550 or N-570)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov
Certificate of Citizenship (N5-560 or N-561)—issued when a person was born outside U.S. to U.S. Citizen parent(s)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov

The following documents may be used to prove citizenship only. You must also provide proof of identity.				
Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Public Birth Record ("Birth Certificate")—must contain original embossed seal	Citizenship—(Must also provide proof of identity)	The state, commonwealth, territory or local jurisdiction	Va. Birth Cert. \$12	For citizens born in Virginia: Department of Health, Division of Vital Records: (804) 662-6200 or www.vdh.virginia.gov (will also assist citizens born outside Virginia with finding contact information for their birth state)

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certification of Report of Birth (FS-240); Consular Report of Birth Abroad of a Citizen of the U.S.A. (FS-545), Certification of Birth Abroad (FS-545)	Citizenship (Must also provide proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
American Indian Card (I-872)	Citizenship (Must also provide proof of identity)	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Contact agency	1-800-375-5283 or www.uscis.gov
Final adoption decree (or statement from state-approved adoption agency if adoption is not finalized)—must show child's name and U.S. place of birth	Citizenship (Must also provide proof of identity)	The state in which the adoption was finalized	Possible copying fee	The court issuing the decree or the adoption agency that handled the adoption
Evidence of Civil Services Employment by the U.S. Government—must show employment by the U.S. government before June 1, 1976	Citizenship (Must also provide proof of identity)	U.S. Office of Personnel Management	Possible copying fee	1-888-767-6738 or www.opm.gov
Official Military Record of Service—must show a U.S. place of birth (e.g. DD-214)	Citizenship (Must also provide proof of identity)	National Archives Allow 6-8 weeks	None	1-866-272-6272 or www.vetrecs.archives.gov
Extract of hospital record on hospital letterhead (not a "birth certificate" issued by a hospital)—must have been established at the time of birth, created at least 5 years before initial application date for Medicaid, and indicate a U.S. place of birth	Citizenship (Must also provide proof of identity)	Hospital of birth	Possible copying fee	Hospital in which individual was born
Life or health or other Insurance Record—must have been created at least 5 years before the initial application date for Medicaid and show a U.S. place of birth	Citizenship (Must also provide proof of identity)	Insurance Company	Possible copying fee	Insurance company that issued the policy—contact information should be listed on the policy

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
A statement signed by the physician or midwife who was in attendance at the time of the birth—must have been created at least 5 years before the date of the initial Medicaid application and show a U.S. place of birth.	Citizenship (Must also provide proof of identity)	Physician or Midwife who delivered the individual	Possible copying fee	Physician or Midwife
Institutional admission papers from a nursing home or other institution or medical records—must have been created at least 5 years before the date of the initial Medicaid application and indicate a U.S. place of birth		Nursing home or other institution in which the individual resides or resided	Possible copying fee	Nursing home or other institution

The following documents may be used to prove identity when you provide proof of citizenship.

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certificate of Degree of Indian Blood; other U.S. American Indian/Alaska Native or Native American tribal document—must have a photograph of individual or other personal identifying information	Identity	U.S. Department of Interior, Bureau of Indian Affairs	Contact agency	(202) 208-3100 or www.doi.gov
Driver's license issued by a state or territory—must have a photograph of individual or other personal identifying information	Identity	State or Territory	\$12 - \$28	In Virginia, Division of Motor Vehicles: 1-866-368-5463 or www.dmv.virginia.gov
School identification (ID) card with photograph of individual	Identity	School	Contact agency	School or school district office
U.S. Military card or draft record; military dependent's ID card		Department of Veteran's Affairs	Contact agency	1-800-827-1000 or www.va.gov
Identification card issued by federal, state, or local government with the same information included on driver's licenses	Identity	Va. Division of Motor Vehicles issues non-driver ID cards	Va. ID \$10	1-866-368-5463 or www.dmv.virginia.gov

M0310.109 COVERED GROUP

A. Definition The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition An individual under age 21 years who has not been legally emancipated from his/her parent(s) is a child.

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a needy child who is:

- under the **age of 18**, or under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF he may be reasonably expected to complete the secondary school, training or program before he attains age 19; and

NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. See section M0310.107 for the definition of a caretaker-relative.

B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency AND is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, nor adoption terminates relationship to the biological relatives.

C. Determining Eligibility**1. Nonfinancial Eligibility**

The QSII individual must:

- meet the nonfinancial eligibility requirement in chapter M02, and
- have been eligible for and receiving Medicaid coverage as an SSI recipient (must have met the more restrictive real property requirement) in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

2. Financial Eligibility**a. Resource Eligibility**

Use the following to determine if the QSII recipient has real property resource(s):

- 1) equity in a non-exempt property contiguous to *the individual's* home which exceeds \$5,000 *and* none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 *are applicable* to the property;
- 2) interest in undivided heir property and the equity value of *the individual's* share *that*, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available.) If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;
- 3) ownership (equity value) of *an individual's* former residence *when* the *QSII* recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;
- 4) equity value in property owned jointly *by the QSII recipient and* another person *who is not the individual's spouse as* tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When a *QSII* recipient has any of the real property listed in 1) through 5) *previously*, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

b. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

D. Entitlement & Enrollment

Eligible individuals are entitled to full Medicaid coverage. They are classified as categorically needy non-money payment (CNNMP) recipients. The program designation is:

- 21 for an aged individual;
- 41 for a blind individual; or
- 61 for a disabled individual.

E. Individuals Ineligible as QSII

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or
- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

M0320.106 PROTECTED ADULT DISABLED CHILDREN

A. Policy

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income \leq 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD with Income \leq 80% FPL.

M0320.201 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipient are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local department of social services.

B. Nonfinancial Eligibility

An individual who is receiving an SSI payment is eligible for Medicaid if he meets the following nonfinancial requirements:

1. Citizenship or Alien Status

The SSI recipient is a citizen of the United States or full benefit alien (see M0220).

2. Virginia Residency

The SSI recipient is a resident of Virginia (see M0230).

3. Assignment Of Rights

The SSI recipient meets the assignment of rights to medical support and third party payments requirements (see M0250).

4. Institutional Status

The SSI recipient meets the institutional status requirements in M0280.

5. Not Conditionally Or Presumptively Eligible

The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

6. SSI Entitlement

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. *When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.*

Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.

C. Financial Eligibility**a. Asset Transfer**

The SSI recipient must meet the asset transfer policy in subchapter M1450. See subchapter M1450 to determine if the asset transfer precludes Medicaid eligibility for *the* Medicaid payment of long-term services.

b. Resource Eligibility

Determine if the SSI recipient has the following real property resource(s):

- 1) equity in non-exempt property contiguous to *the individual's* home which exceeds \$5,000 *and* none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 *are applicable* to the property;
- 2) interest in undivided heir property and the equity value of *the individual's* share *that*, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available.) If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;
- 3) ownership (equity value) of *the individual's* former residence *when* the SSI recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;
- 4) equity value in property owned jointly *by the SSI recipient* with another person in *who is not the individual's spouse* as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as medically indigent (which has more liberal resource methods and standards).

When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

D. Entitlement and Enrollment

1. Entitlement

Eligibility in the FPS covered group cannot extend *beyond* the 24th month following the end of a woman's pregnancy. *The woman is entitled to coverage in the FPS covered group for 12 months (including the 60-day post-partum period) from the date the pregnancy ends. Changes in income during the first 12 months of FPS coverage do not affect the woman's eligibility for FPS.*

Women who were not enrolled in the MI Pregnant Women covered group who had a Medicaid covered pregnancy-related service must have an eligibility determination. If the woman does not meet a covered group entitled to full Medicaid benefits, but meets the requirements of the FPS covered group, she is to be enrolled in FPS.

Written notice must be sent to inform the recipient of her eligibility in the FPS covered group and of the reduction in coverage. She must also be advised of the opportunity to receive a redetermination of eligibility for full coverage.

2. Enrollment

The eligibility worker must cancel the MI Pregnant Women enrollment effective the last day of the month of the 60-day postpartum period and *reinstate* the woman in FPS the first day of the following month.

The AC for FPS is "080".

The eligibility worker must enter the actual date of the child's birth, or the actual date the pregnancy terminated, in the Expected Delivery Date field on the recipient's demographics screen in MMIS. MMIS will automatically send the advance notice and cancel FPS coverage 24 months after the pregnancy ends, *unless the woman becomes ineligible for FPS services after the 12th month from the end of pregnancy and her coverage is canceled by the worker.* The MMIS will cancel this coverage using reason code "036".

*The eligibility of a woman enrolled in FPS must be evaluated 12 months following the **end of the pregnancy**. If the woman continues to be eligible for FPS, her coverage may continue for an additional 12 months. Changes in income after the first 12 months of FPS coverage must be evaluated. See section MI520.200 C for the FPS renewal requirements.*

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)

A. Policy

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to

100% of the FPL and allows states to cover children at higher income limits. Virginia has elected to cover children between the ages of 6 and 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The *ACs* for the MI child are:

<i>AC</i>	Meaning
090	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	MI child under age 6; income less than or equal to 100% FPL
092	<ul style="list-style-type: none"> MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; MI child age 6-19; insured with income greater than 100% FPL and less than or equal to 133% FPL
94	MI child age 6-19; uninsured with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the *AC* when a child's health insurance is paid for by Medicaid through the HIPPP program.

**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY INCOME)
EFFECTIVE 07/01/06**

FAMILY/BUDGET UNIT SIZE	GROUP I	GROUP II	GROUP III
1	<i>313.04</i>	<i>373.10</i>	<i>521.04</i>
2	<i>491.03</i>	<i>551.07</i>	<i>701.16</i>
3	<i>632.55</i>	<i>690.47</i>	<i>842.72</i>
4	<i>767.66</i>	<i>827.70</i>	<i>979.94</i>
5	<i>904.91</i>	<i>979.94</i>	<i>1162.23</i>
6	<i>1014.25</i>	<i>1091.45</i>	<i>1271.59</i>
7	<i>1147.22</i>	<i>1222.26</i>	<i>1404.54</i>
8	<i>1290.90</i>	<i>1363.81</i>	<i>1544.01</i>
9	<i>1408.82</i>	<i>1483.90</i>	<i>1670.45</i>
10	<i>1539.67</i>	<i>1616.86</i>	<i>1799.05</i>
each addt'l person add	<i>130.78</i>	<i>130.78</i>	<i>130.78</i>

F&C MONTHLY INCOME LIMITS EFFECTIVE 7/1/06

GROUP I

Family/Budget Unit Size	100%	90%
1	<i>169.21</i>	<i>151.82</i>
2	<i>265.42</i>	<i>239.91</i>
3	<i>341.91</i>	<i>307.14</i>
4	<i>414.95</i>	<i>373.22</i>
5	<i>489.14</i>	<i>440.45</i>
6	<i>548.24</i>	<i>494.93</i>
7	<i>620.12</i>	<i>558.68</i>
8	<i>697.78</i>	<i>627.06</i>
9	<i>761.53</i>	<i>685.03</i>
10	<i>832.24</i>	<i>749.93</i>
Each person above 10	<i>70.69</i>	<i>64.88</i>

GROUP II

Family/Budget Unit Size	100%	90%
1	<i>201.68</i>	<i>181.96</i>
2	<i>297.88</i>	<i>267.74</i>
3	<i>373.22</i>	<i>337.28</i>
4	<i>447.40</i>	<i>402.19</i>
5	<i>529.70</i>	<i>474.11</i>
6	<i>589.97</i>	<i>530.86</i>
7	<i>660.69</i>	<i>593.45</i>
8	<i>737.19</i>	<i>663.01</i>
9	<i>802.11</i>	<i>722.12</i>
10	<i>873.98</i>	<i>785.87</i>
Each person above 10	<i>70.69</i>	<i>64.88</i>

F&C MONTHLY INCOME LIMITS EFFECTIVE 7/01/06**GROUP III**

Family/Budget Unit Size	100%	90%
1	<i>281.64</i>	<i>255.00</i>
2	<i>379.01</i>	<i>340.77</i>
3	<i>455.52</i>	<i>410.32</i>
4	<i>529.70</i>	<i>475.23</i>
5	<i>628.23</i>	<i>565.64</i>
6	<i>687.34</i>	<i>618.95</i>
7	<i>759.21</i>	<i>683.87</i>
8	<i>834.59</i>	<i>753.42</i>
9	<i>902.95</i>	<i>812.54</i>
10	<i>972.45</i>	<i>875.12</i>
Each person above 10	<i>70.69</i>	<i>64.88</i>

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-06

GROUP I			GROUP II		GROUP III	
# of Persons in Family/ Budget Unit	Semi- Annual Income	Monthly Income	Semi- Annual Income	Monthly Income	Semi- Annual Income	Monthly Income
1	\$1506.87	\$251.14	\$1738.70	\$289.78	\$2260.30	\$376.71
2	1918.80	319.80	2141.31	356.88	2725.36	454.22
3	2260.30	376.71	2492.13	415.35	3071.70	511.95
4	2550.09	425.01	2781.92	463.65	3361.48	560.24
5	2839.87	473.31	3071.70	511.95	3651.27	608.54
6	3129.66	521.61	3361.48	560.24	3941.05	656.84
7	3419.44	569.90	3651.27	608.54	4230.84	705.14
8	3767.18	672.86	3999.01	666.50	4520.62	753.43
9	4114.93	685.82	4346.75	724.45	4926.32	821.05
10	4520.62	753.43	4752.45	792.07	5274.07	879.01
Each add'l person add	389.46	64.91	389.46.	64.91	389.46	64.91

B. Earned Income Exclusions

Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.

See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.

1. Workforce Investment Act Income

Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.

2. Student Income

Earned income of an *individual* under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.

3. Standard Work Exclusion

A standard work exclusion of the first \$90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. For LIFC, the standard work exclusion is not allowed in the 185% screening. See M0720.520.

4. \$30 Plus 1/3 Earned Income Exclusion

For the LIFC covered group only, \$30 plus 1/3 of the remaining monthly earned income is excluded for 4 consecutive months from the total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The \$30 plus 1/3 earned income exclusion is not allowed in the 185% screening. See M0720.525.

5. \$30 Earned Income Exclusion

For the LIFC covered group only, \$30 per month earned income is excluded for 8 consecutive months following the receipt of 4 months of the \$30 plus 1/3 earned income exclusion from total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The \$30 earned income exclusion is not allowed in the 185% screening. See M0720.526.

6. Child Care/Incapacitated Adult Care Exclusion

Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. For LIFC, the child care/incapacitated adult care exclusion is not allowed in the 185% screening. See M0720.540.

**M0720.505 WORKFORCE INVESTMENT ACT INCOME
EXCLUSION****A. Policy**

Earned income of any eligible child derived from employment under the Workforce Investment Act is excluded. Do not request verification of earnings under the Workforce Investment Act.

M0720.510 STUDENT EARNED INCOME EXCLUSION**A. Policy**

Earned income of an *individual* under age 19 who is a student is excluded. Do not verify school enrollment or request verification of student earned income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Declaration of school attendance is sufficient for the student earned income exclusion.

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a *covered group*; and
- meets the nonfinancial requirements; and
- meets the *covered group's* resource limits; and
- meets the *covered group's* income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits

The Medicaid *covered group* determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy *covered group*.

2. Categorically Needy Non-Money Payment-Protected Cases Only

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$603	\$579
2	904	869
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$402	\$386
2	602.67	579.34

**3. Categorically
Needy-Non
Money Payment
(CNNMP) -
300% of SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

Categorically Needy-Non Money Payment 300% of SSI		
Family Size Unit 1	2006 Monthly Amount \$1,809	2005 Monthly Amount \$1,737

**4. Medically
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$1506.87	\$ 251.14
2	1918.80	319.80
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	1738.70	\$ 289.78
2	2141.31	356.88
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$2260.30	\$ 376.71
2	2725.36	454.22

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/24/06; and
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/06**

ABD 80% FPL 1 2	Annual \$ 7,840 10,560	Monthly \$ 654 880
QMB 100% FPL 1 2	Annual \$ 9,800 13,200	Monthly \$ 817 1,100
SLMB 120% of FPL 1 2	Annual \$11,760 15,840	Monthly \$ 980 1,320
QI 135% FPL 1 2	Annual \$13,230 17,820	Monthly \$1,103 1,485
QDWI 200% of FPL 1 2	Annual \$19,600 26,400	Monthly \$1,634 2,200

**4. Contact with
OPM**

If the individual has no acceptable documents, write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven-digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security number.

The OPM telephone number is (888) 767-6738. Direct written inquiries to:

U.S. Office Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017

S0830.225 RAILROAD RETIREMENT PAYMENTS

A. Introduction

**1. Categories of
Payment**

There are three basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities
- Social Security benefits certified RRB
- Unemployment, sickness, and strike benefits

**2. Life and
Survivor
Annuities**

- Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.
- Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
- RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, cost of living adjustments (COLA) for RR annuities are effective the same month as Title II COLA's.

**3. Social Security
Benefits
Certified by
RRB**

SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. In these situations, RRB *is* responsible for certifying Title II benefits to Treasury, *but* they remain Title II benefits.

RR benefits are not necessarily Title II benefits. Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

**4. Unemployment
Sickness, and
Strike Benefits**

Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

B. Policy

**1. Unearned
Income**

Payments made by the RRB are unearned income.

**2. Reduction of
RR Benefits**

The amount deducted from a RR benefit for supplementary medical insurance (SMI) premiums is unearned income. See S0830.110 if an overpayment is involved.

**3. Countable RR
Income**

The amount of the RR annuity to count as income is the amount before the collection of any obligations of the annuitant (unless the exception in S0830.110 applies).

**C. Procedure - Life
and Survivor
Annuities**

**1. General
Development --
All Cases**

- a. Be alert to the possibility of the receipt of, or potential entitlement to, RR benefits in every case where:
 - the individual's social security number begins with a "7"
 - the individual alleges or other evidence indicates railroad employment by the individual or his/her spouse.
- b. Verify allegations of receipt of RR annuities by obtaining a copy of the individual's most recent award notice.
- c. If the notice is unavailable, record in the file the information from the individual's next check.

NOTE: RR checks bear beneficiary symbols that identify the type of RR benefit involved.

**D. Procedure for
Social Security
Benefits Certified
By RRB**

The applicant should have notices issued by SSA and RRB indicating that the benefit is a Title II benefit. If Title II status cannot be determined from the available documents, verify with the RRB that RR benefits are Title II benefits.

**E. Procedure -
Unemployment,
Sickness, and Strike
Benefits**

Obtain evidence of unemployment, sickness, and strike benefits from the individual's own records, such as an award letter or actual check. If this evidence is unavailable, contact *the* RRB headquarters *by telephone at (312) 751-7139 or by mail at:*

Railroad Retirement Board
844 North Rush Street
Chicago, IL 60611-2092

Local RRB offices do not maintain this information.

2. Joint Tenancy

a. Each Owner Has Same Interest

In joint tenancy, each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all of the property.

b. Survivorship Rights

Upon the death of one of only two joint tenants, the survivor becomes sole owner. On the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

c. Conversion to Tenancy-in-Common

In most States, it is possible for joint tenants to take action during their lifetime to convert the joint tenancy to a tenancy-in-common (see 1. above).

3. Tenancy by The Entirety

a. Married Couples Only

A tenancy by the entirety can exist only between the members of a married couple. The wife and husband as a unit own the entire property which can be sold only with the consent of both parties. However, if a marriage has been legally dissolved, the former spouses become tenants-in-common and one can sell his or her share without the consent of the other.

b. Survivorship Rights

Upon the death of one tenant by the entirety, the survivor takes the whole.

**D. Operating Policy--
Shared Ownership**

1. General Rule

With the exception noted below, we assume, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. We divide the total value of the property among all of the owners in direct proportion to the ownership share held by each.

**2. Exception:
Checking/
Savings
Accounts and
Time Deposits**

For a joint checking or savings account or a jointly-owned time deposit, we assume that all of the funds in the account belong to the applicant(s) recipient(s), in equal shares if there is more than one applicant or recipient (S1140.205 B and .210 B).

**3. Determining the
Countable
Value of Jointly
Owned Real
Property**

The procedures for determining the countable value of jointly owned real property are found in Appendix 1 to subchapter S1130.

M1110.515 OWNERSHIP IN FEE SIMPLE OR LESS THAN FEE SIMPLE

A. Definitions

1. Fee Simple

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

2. Less than Fee Simple Ownership

- a. Life Estate - A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.
- b. Equitable ownership - An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). See C. below.

B. Description-- Life Estate

1. Rights of Life Estate Owner

a. What Owner Can Do

Unless the instrument (will or deed) establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.

A life estate in real property (life rights) is not counted as a resource when it was obtained prior to February 8, 2006.

*For a life estate obtained on or after February 8, 2006, the life rights are not counted as a resource when the property serves as the individual's principal place of residence. Life rights obtained on or after February 8, 2006, **are countable** when the property no longer serves as the individual's place of residence. See M1140.110.*

b. What Owner Cannot Do

A life estate owner owns the physical property only for the duration of the life estate. The owner generally can sell only his or her interest; i.e., the life estate. The owner cannot take any action concerning the interest of the remainderman.

2. Remainder Interest

a. Future Interest in Physical Property

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more others (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

b. Sale of Remainder Interest

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

3. Example

Mr. Heath, now deceased, had willed to his daughter a life estate in property which he had owned in fee simple. The will also designated Mr. Heath's two sons as remaindermen. Ms. Heath has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

C. Policy--Equitable Ownership Interest

Basically, existence of an equitable ownership interest is determined by a court of equity.

1. Unprobated Estate

For Medicaid purposes, an individual may have an equitable ownership interest in an unprobated estate if he or she:

- is an heir or relative of the deceased;
- receives income from the property; or
- has acquired rights in the property due to the death of the deceased in accordance with State intestacy laws.

M1120.215 contains instructions on how to determine whether an interest in an unprobated estate is a resource.

2. Trust

A trust is a right of property established by a trustor or grantor. One party (trustee) holds legal title to trust property which he or she manages for the benefit of another (beneficiary). The beneficiary does not have legal title but does have an equitable ownership interest.

M1120.200 contains instructions concerning resources treatment of trusts in the Medicaid program.

M1120.201 contain instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

An individual may acquire an equitable ownership interest in his or her home through personal considerations or by performing certain activities such as:

- making mortgage payments or paying property taxes;
- making or paying for additions to a shelter; or
- making improvements to a shelter.

M1130.100.E.1 contains instructions on how to determine whether equitable ownership in home property exists.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest, i.e., the right to use or possess the property.

B. Definitions**1. Leasehold**

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not convey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

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**F. Example--
Installment Sale
Contract**

1. Situation

Henry Little, a Medicaid applicant, recently became a widower and moved out of the family home to live in a rented apartment. He has just entered into an installment sale contract on his former home with Thomas Higgins, a Medicaid recipient. Mr. Higgins made a \$6,000 down payment on the house, using retroactive SSI benefits paid under a court order, and immediately moved into his new home in which he already has an equitable ownership interest, even though he does not yet have title. The outstanding principal balance on the installment agreement is \$8,000.

2. Analysis

The EW must determine resources eligibility for both men. Although Mr. Little still has title to the house, he cannot sell it; rather, its value as a resource to Mr. Little has folded into the value of the installment contract. However, the installment sale contract (which the EW confirms has no legal restrictions against its sale) is Mr. Little's resource in the amount of the outstanding principal balance unless he presents convincing evidence that its CMV is a lower amount.

The installment sale contract has no bearing on Mr. Higgins' eligibility, as either income or resources. His ownership interest in the house he is buying from Mr. Little is an excluded resource since it is his principal place of residence.

M1120.225 REVERSE MORTGAGES

A. Definition

A reverse mortgage is a contract with a bank or other lending institution whereby the bank provides the borrower with monthly payments which do not have to be repaid as long as the individual lives in the home. These payments are a loan against the equity in the home and must be repaid when the individual dies, sells his home, or moves.

B. Policy

The payments from a reverse mortgage are loan proceeds and are not income to the borrower. Proceeds retained after the month of receipt are a resource.

D. Procedure
Accelerated Life
Insurance Payments

If an individual receives accelerated payments, and the payments do **not** preclude Medicaid eligibility due to excess income or resources, determine whether the FV and/or CSV of the policy must be verified.

Reverify the policy if, prior to receipt of the accelerated payments:

- the policy's CSV precluded Medicaid eligibility, but the individual may now be resource-eligible; or
- the policy was an excluded resource and its FV reduced the maximum burial fund exclusion available to the individual (see B.4. above).

If reverification is necessary, examine the policy and any other relevant documentation in the individual's possession to determine the effect of the accelerated payments on FV and CSV. If necessary, contact the life insurance company for the necessary information.

If the individual expects to receive accelerated payments in the future, explain the effect of any further reduction in the policy's FV on the maximum burial fund exclusion available (if applicable).

E. References

- Income treatment of life insurance dividends, S0830.500 C.
- Life insurance funded burial contracts, **M1130.425**.

M1130.400 BURIAL SPACES**A. Policy –The
Exclusion****1. General**

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Cemetery plots are not *counted as resources, regardless of the number owned*, except when evaluating eligibility as QDWI. For QDWI, exclude one cemetery plot (see Appendix 1 to chapter S11).

**2. No Effect on
Burial Funds
Exclusion**

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion (M1130.410).

**3. Multiple Burial
Spaces**

When items other than cemetery plots serve the same purpose, exclude only one per person. For example, exclude a cemetery plot and a casket for the same person, but not a casket and an urn.

B. Definitions**1. Burial Space**

A burial space is a(n).

- Gravesite (*either an existing grave or a plot*);
- crypt;
- mausoleum;
- casket;
- urn;
- niche; or
- other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- vaults;
- headstones, markers, or plaques;
- burial containers (e.g., for caskets); and
- arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

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S1140.042 DETERMINING EQUITY VALUE

- A. Operating Policy** Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility.
- B. Development and Documentation**
- 1. Statement** If an individual alleges a debt against the resource in question, obtain his or her signed description of the debt.
- 2. Verification**
- a. **Verify**, at a minimum:
- the outstanding principal balance of any month for which a determination must be made; and
 - **Obtain** a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, you may use other records of the individual, the creditor, or both.
- 3. *Determining the Countable Value of Real Property*** *The procedures for determining the countable value of real property are found in Appendix 1 to subchapter S1130.*
- C. Example-Equity Value Permits Eligibility for Limited Time**
- The Rounds, an aged couple, file for Medicaid in January 1994. Their countable liquid resources total \$1,500. They also own nonhome real property with a CMV of \$2,000, which would cause their total resources to exceed the \$3,00 limit.
- However, there is a mortgage on the land with an outstanding principal balance of \$800. Thus, the property's equity value (\$1,200) currently permits eligibility.
- Payments on the mortgage reduce the outstanding principal balance by \$80 a month. At that rate, the property's equity value will reach \$1,520 in May 1994, and resources will exceed the limit.

S1140.044 RESOURCES WITH ZERO VALUE

- A. Policy Principal** Property that meets the definition of a resource (S1110.100 B.1.) is a resource even if it has no value to count; i.e., has a CMV of zero (S1110.100 B.2.).
- B. Operating Policy** An unsuccessful attempt to sell property at its estimated CMV may suggest that the property has a lesser CMV than estimated, but does not necessarily mean that the property has no CMV at all.

C. Related Policies

- | | |
|--------------------------------------|--|
| 1. Reasonable Efforts to Sell | For the effect of reasonable but unsuccessful efforts to sell real property see M1130.140. |
| 2. Conversion of a Resource | Should property that has been determined to have no CMV be sold, the proceeds of the sale represent the conversion of a resource, not income (S1110.600 B.4.). |

REAL PROPERTY

S1140.100 NON-HOME REAL PROPERTY

- | | |
|--|---|
| A. Definition | Non-home real property consists of land and buildings or immovable objects (including some mobile homes) that are attached permanently to the land and that do not meet the definition of a home (M1130.100). |
|
B. Operating Policy-- Assumptions | |
| 1. Sole Ownership | Absent evidence to the contrary, accept an individual's allegation of sole ownership of property. |
| 2. Marketability | Absent evidence to the contrary, assume that an individual can sell the property at its estimated CMV. |
| C. Development and Documentation Shared Ownership | <p>Document an allegation of shared ownership with any of the following evidence:</p> <ul style="list-style-type: none">• a tax assessment notice or bill;• a current mortgage statement;• a deed;• a report of title search;• wills, court records, or other documentation of inheritance. <p>If the individual alleges owning other than an equal share of the property (e.g., alleges having a 25 percent ownership interest where there are only two owners), the evidence must support that allegation, as well.</p> |

M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. **Mineral Rights** Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
2. **Timber Rights** Timber rights permit one party to cut and remove free standing trees from the property of another property.
3. **Easements** An easement gives one party the right to use the land of another party for a special purpose.
4. **Leaseholds** A leasehold gives one party control over certain property of another party for a specified period. In some States, a "lease for life" can create a life estate under common law.
5. **Water Rights** Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.
6. **Life Estates** A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage.

The owner of a life estate can sell the life estate but does not have title to the property and thus normally cannot sell it or pass it on as an inheritance.

a. Life Rights Obtained Before February 8, 2006

For covered groups other than Qualified Disabled Working Individuals (QDWI), life rights to real property are not counted as a resource.

b. Life Rights Obtained On or After February 8, 2006

For covered groups other than QDWI, life rights to real property are not counted as a resource when the property serves as the principal place of residence. Life rights to real property are a countable resource when the property no longer serves as the individual's place of residence.

Life rights to real property are countable for the QDWI covered group (see Appendix 1 to chapter S11).

7. **Remainder Interests** When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. **General** Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral Rights

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

b. Ownership of Mineral Rights Only

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate or Remainder Interest

a. General

Using the table in S1140.120, multiply the CMV of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

If there is more than one life estate, divide the equity value of the real property by the number of people having a life estate interest. Multiply the prorated equity value of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

b. 1) *Life rights obtained before February 8, 2006:*

For covered groups other than Qualified Disabled Working Individuals (QDWI), life estate in real property is not counted as a resource to the applicant or recipient.

2) *Life rights obtained on or after February 8, 2006:*

For covered groups other than QDWI, life estate in real property is not counted as a resource to the applicant or recipient when the property serves as the principal place of residence. Life rights to real property are a countable resource when the property no longer serves as the individual's place of residence. The policy in M1130.140 governing reasonable efforts to sell real property applies to life estates.

Life estate in real property is countable for the QDWI covered group (see Appendix 1 to chapter S11).

c. Any countable equity value of real property would be affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers their real property retaining a life estate interest, thus affecting the value for evaluation of transfer of assets.

See S1140.120 Life Estate and Remainder Interest Tables to determine CMV of real property owned by an applicant or recipient.

3. Value
 - a. Series E, EE, and I paper bonds
 - **On-line Verification** at:
<http://www.publicdebt.treas.gov/sav/savcalc.htm>
 - Current copy of the Table of Redemption Values for US Savings Bonds
 - **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.
 - b. Series E, EE, and I electronic bonds
 - Ask individual to obtain his "Current Holdings" list from the Treasury web site at: <http://www.savingsbonds.gov/>
 - Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.
 - c. **Series H and HH Bond After Maturity**
After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.
4. Photocopy Document the file with a photocopy or certification of the bond(s). See **S1140.010 C.** on photocopying U.S. Government obligations.
5. Follow-up, if Appropriate If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. **Bond** A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
2. **Municipal Bond** A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).
3. **Corporate Bond** A corporate bond is the obligation of a private corporation.
4. **Government Bond** A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

- B. Operating Policy** Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

- C. Development and Documentation** Development and documentation instructions for stocks (S1140.220) also apply to bonds.

M1140.260 ANNUITIES

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity *means* a contract or an agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity must be issued by an insurance company, bank, or other registered or licensed entity approved to do business in the state in which the annuity was established.

B. Operating Policy

1. *An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable. The countable value of the revocable annuity is the amount of the funds in the annuity minus any fees required for surrender.*
2. *Annuities purchased with the assets of a third party such as those received through a legal settlement are not considered to be countable resources.*
3. *An annuity issued prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender.*
4. *A non-employment related annuity purchased by or for an individual on or after February 8, 2006, using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity*
 - (a) is irrevocable;*
 - (b) is non-assignable;*
 - (c) is actuarially sound; and*
 - d) provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.*
5. *Prior to receiving long-term care services paid by Medicaid, all annuities purchased by the institutionalized individual or the community spouse on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.*
6. *For individuals applying for long-term care services, annuities owned by either the applicant or the applicant's spouse must also be evaluated using the policy in M1450.200 to determine whether an uncompensated asset transfer has occurred.*

S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

1. General

The context of the instruction in this section is the individual as the creditor (lender of money, seller of property) and, therefore, as the owner of the promissory note, loan, or property agreement.

See S1120.220 for additional information on notes, loans and property agreements.

2. Promissory Note

A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

3. Loan

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note.

4. Property Agreement

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements—e.g., pledges of crops, fixtures, inventory, etc.—are commonly known as chattel mortgages.

B. Operating Policy

1. Real Estate Contracts Prior to Settlement

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed: the real estate and the contract. The real estate is not a resource because the individual cannot convert it to food or shelter. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.

2. Value as a Resource Assumption

Assume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than *the outstanding principal balance* (or no CMV at all).

**C. Development and
Documentation –
Written Agreement**

- 1. Copy of Agreement**

Obtain a copy of the agreement for the file. Cease development if including the original balance in countable resources does not cause ineligibility.
- 2. Principal Balance**

If including the original balance in countable resources causes ineligibility and payments have been made, obtain evidence of the outstanding principal balance.

Cease development if including the outstanding principal balance in countable resources does not cause ineligibility.
- 3. Rebuttal Rights**

If including the outstanding principal balance in countable resources causes ineligibility, **inform the individual** that we will use the outstanding principal balance in determining resources unless he or she submits:

 - evidence of a legal bar to the sale of the agreement ; or
 - an estimate from a knowledgeable source, showing that the CMV of the agreement is less than its outstanding principal balance.
- 4. Knowledgeable Sources**

Knowledgeable sources include anyone regularly engaged in the business of making such evaluations: e.g., banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source.

D. Related Policy

- 1. Loans and the Borrower**

See S1120.220 on how to determine whether the proceeds of a loan are income or a resource to the borrower.
- 2. Home Replacement Funds Exclusion**

See S1130.110 when a contract is from the sale of an excluded home.
- 3. Individuals Requesting Long-term Care**

For individuals requesting Medicaid payment for long-term care who have purchased promissory notes, loans, or mortgages on or after February 8, 2006, see M1450.540.

M1140.305 CONTINUING-CARE RETIREMENT COMMUNITY ENTRANCE FEES

A. Introduction

Continuing-care or life-care retirement communities generally provide guaranteed care for the life of the individual in return for a set entrance fee as well as monthly maintenance fees. If the applicant has entered into a continuing-care contract or agreement with a retirement community, the entrance fee paid by the individual to the retirement community must be evaluated.

B. Operating Policy

An individual's entrance fee paid to a continuing-care retirement or life-care retirement community that collects an entrance fee upon admission shall be considered an available resource if:

- *the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;*
- *the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing-care or life-care contract and leaves the retirement community; and*
- *the entrance fee does not confer an ownership interest in the continuing-care retirement community or life-care community.*

C. Development and Documentation

1. Copy of Contract/Agreement

Obtain a copy of the contract or agreement. If one or more of the conditions in B. above is not met in the terms of the contract, do not develop the contract further as a resource..

2. Countable Value of Entrance Fee

If all of the conditions in B. above are met in the terms of the contract or agreement, determine the countable value of the entrance fee. Contact the retirement community to determine:

- *the amount of the entrance fee actually paid if the contract or agreement stipulates installment payments, and*
- *whether any amount has been refunded to the applicant.*

Subtract any amount that the retirement community has refunded from the amount paid. Document the resulting balance in the case record as a countable resource.

M1140.310 LIFE INSURANCE

A. Introduction

This section provides broad policy principles concerning the treatment of life insurance policies for Medicaid purposes. Detailed instructions on the development and, where applicable, the exclusion of life insurance are contained in M1130.300.

B. Policy Principles

1. Countability Based on Total Face Value

If the combined face values of all the life insurance policies an individual, owns on a given insured age 21 or older, exceed \$1,500, the cash surrender value of any such policy is a resource to the individual.

2. Policies Whose Face Values Are Not Taken into Account

For purposes of determining whether the combined face values of all the life insurance policies an individual owns on a given insured age 21 or older, exceed \$1,500, the face values of the following are not taken into account:

- term insurance that does not have a cash surrender value; and
- burial insurance; i.e., insurance whose terms preclude the use of policy proceeds (proceeds include any cash surrender value) for any purpose other than payment of the insured's burial expenses.

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M1440.102 MENTAL RETARDATION WAIVER

- A. General Description** The Mental Retardation Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR.
- B. Targeted Population** The targeted population groups of individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded are:
- individuals with mental retardation diagnosis;
 - individuals under the age of six who are at developmental risk and who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded. At age 6, these individuals must be determined to be mentally retarded in order to continue to receive CBC waiver services.
- C. Eligibility Rules** All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.
- The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.
- D. Services Available** Services available under the MR waiver:
- day support
 - supported employment
 - residential support
 - therapeutic consultation
 - *agency-directed and consumer-directed* personal assistance services
 - *agency-directed and consumer-directed* respite care
 - nursing services
 - environmental modification
 - assistive technology
 - *agency-directed and consumer-directed adult companion services*
 - *crisis stabilization*
 - *prevocational services*
 - *Personal Emergency Response System (PERS)*
 - *therapeutic consultation.*
- E. Assessment and Service Authorization** The individual's need for CBC is determined by the Community Mental Health Services Board (CSB) or Department of Rehabilitative Services (DRS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to DMHMRSAS or DMAS staff for final authorization.

1. CSB

The CSB case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is mentally retarded, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DRS

The DRS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
- the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 AIDS WAIVER

A. General Description

The AIDS waiver provides services to individuals with HIV infection to prevent hospitalization or nursing facility placement.

B. Targeted Population

The waiver services are for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency Syndrome) or who are HIV positive and are symptomatic, and for whom the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

C. Eligibility Rules

Patients receiving AIDS waiver services must meet the non-financial and financial Medicaid eligibility criteria applicable to the other Medicaid covered groups and must be Medicaid-eligible in a medical institution. These individuals are considered as if they were institutionalized for the purpose of applying institutional resource and income rules.

The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

Services available under the AIDS Waiver *include*:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care.

E. Assessment and Service Authorization

Status as an AIDS individual in need of CBC shall be determined by the pre-admission screener.

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term services (facility or CBC) for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of long-term care.

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants about transfers of both income and resources that occurred during the **five years** before the Medicaid application date. Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1420.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act), enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA)

The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.

E. The Code of Virginia

Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets, and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

M1450.003 DEFINITION OF TERMS**A. Assets**

For the purposes of asset transfer, assets are all income and resources of the individual and the individual's spouse, including any income and resources to which the individual or the spouse is entitled but does not receive because of an action by:

- the individual or the spouse,
- any person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or spouse, or,
- a person, including a court or administrative body, acting at the direction or request of the individual or spouse.

The term "asset" may also include:

- life estate (life rights) in another individual's home, and
- the funds used to purchase a promissory note, loan, or mortgage.

B. Asset Transfer

An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual's ownership or control of an asset(s). Transfers include

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgement against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

When the placement of a lien or a judgement against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by Black's Law Dictionary, is a

transaction negotiated by **unrelated** parties, each acting in his or her own self interest. When an individual's relative has a lien or judgment against the individual's property, the lien or judgement is an asset transfer that must be evaluated under policy in sections M1450.400.

C. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined below) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

D. Fair Market Value

Fair market value is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility. For example, the fair market value of real property is the tax assessed value.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

E. Income

Anything received by an individual or the individual's spouse to meet the individual's basic needs for food, shelter, and clothing is **income**. See subchapter M1460 for items that are not income.

F. Institutionalized Individual

An **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals (including rehabilitation hospitals and rehabilitation units of general hospitals) and patients in

Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSA) facilities who are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded; *or*

- a person who *has been screened and approved for or is receiving* Medicaid community-based care (CBC) waiver services.

G. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over \$500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. the parties to the contract were legally competent to enter into the contract. (Generally, this excludes insane people; sometimes it excludes children. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract)
2. “valuable consideration” is received by each party (this roughly equates to the “adequate compensation” requirement of the asset transfer rules)
3. contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. *For example*, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must, for example, set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.
4. contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

H. Look-Back Date

The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers *that* take place on or after the look-back date. Penalties cannot be imposed for transfers *that* take place before the look-back date.

1. Transfers Made Before February 8, 2006

- a. In the case of a **revocable trust**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 60 months before the baseline date.
- b. In the case of an **irrevocable trust from which payment can be made to the individual**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 36 months before the baseline date.

- c. In the case of an **irrevocable trust from which payment CANNOT be made to the individual**, the transfer of assets into the trust is considered an asset transferred for less than fair market value as of the date the trust was established. The look back date is 60 months before the baseline date.

**2. Transfers Made
On or After
February 8,
2006**

The look-back date is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. This policy applies to applications processed on or after July 1, 2006, for transfers made on or after February 8, 2006.

I. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date.

**1. Transfers Made
Before
February 8,
2006**

The look-back period is 36 months (or 60 months in the case of a trust that is treated as an asset transferred for less than market value) prior to the baseline date.

**2. Transfers Made
On or After
February 8,
2006**

The look-back period is 60 months. This policy applies to applications processed on or after July 1, 2006, for transfers made on or after February 8, 2006.

J. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

**K. Payment
Foreclosed**

Payment to the individual from an irrevocable trust is **foreclosed** when

- a payment is made from the trust to another person and not for the benefit of the individual.

the trust document contains a clause that describes the time and/or conditions under which the trustee must stop making payments to the individual (an "exculpatory" clause), and the clause takes effect; e.g., the trust document states that the trustee must stop making any payments to the individual beneficiary if the individual is admitted to a nursing facility; payment from the trust to the individual is foreclosed the date he is admitted to a nursing facility.

L. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the transferred assets and the average cost of nursing facility care in Virginia.

- M. Property/ Resources** “Property” and “resources” both refer to real and personal property legally available to the individual or the individual's spouse.
- N. Uncompensated Value** The **uncompensated value** of a transferred asset is the difference between the asset’s fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

M1450.004 POLICY PRINCIPLES

- A. Policy** An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services.
- B. Organization of Policy in This Subchapter** *The treatment of the asset transfer depends on the date of the transfer. Certain areas of policy in this subchapter are divided into separate sections or subsections that address (1) asset transfers on or after August 11, 1993, but prior to February 8, 2006 and (2) asset transfers on or after February 8, 2006. Where no date is specified in the policy, the policy applies to all asset transfers on or after August 11, 1993. Contact a Medical Assistance Program Consultant for guidance when an asset was transferred prior to August 11, 1993.*
- C. Procedures**
1. At application, ask the individual if he or his spouse transferred ownership of, sold, or gave away any asset before July 1, 1988. Also at application, ask the individual if he or his spouse transferred ownership of, sold, or gave away any asset within the past 5 years.
 2. If the applicant answers yes, determine the date(s) the asset(s) was transferred.
 3. If the transferred asset was income:
 - Do not evaluate income transfers made **before** 8-11-93; income transfers made before 8-11-93 do not affect eligibility.
 - Evaluate income transfers made on or after 8-11-93 to determine effect on eligibility for Medicaid LTC services.
 4. *For asset transfers prior to August 11, 1993, contact a Medical Assistance Program Consultant.*
 5. For all other asset transfers, evaluate the transfer using sections M1450.100 and M1450.200 below and other applicable sections, based on the date the transfer occurred.

**M1450.100 TRANSFERS ON OR AFTER AUGUST 11, 1993 *BUT BEFORE*
FEBRUARY 8, 2006**

- A. Policy**
- An institutionalized individual who disposes of, or whose spouse disposes of, assets for less than fair market value on or after the look-back date specified in subsection B below is ineligible for Medicaid payment of LTC services (nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home or community-based services furnished under a CBC waiver). This rule applies to asset transfers occurring on or after August 11, 1993.
- Once an individual has established eligibility for Medicaid payment of LTC services, transfer of assets owned by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.
- B. Procedures**
- When an enrolled Medicaid recipient is institutionalized, review his/her eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant. Take the following actions to determine if an asset transfer affects eligibility for Medicaid payment of long-term care services:
- 1. Transfers Not Involving Trusts**

Determine if any assets of the individual or the individual's spouse were transferred during the 36 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

 - 2. Transfers Involving Trusts**

Determine if any of the individual's or the individual's spouse's assets were transferred into or from a trust fund during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

 - 3. Determine Effect**

If an asset was transferred during any of the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.300 through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.620).

M1450.200 TRANSFERS ON OR AFTER FEBRUARY 8, 2006

- A. Policy** *The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers. **The policy in this section applies to applications processed on or after July 1, 2006 for transfers made on or after February 8, 2006. For applications processed prior to July 1, 2006, use the policy in M1450.100.***
- B. Procedures** *When a Medicaid recipient is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant.*
- 1. All Transfers** *Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.*
- 2. Determine Effect** *If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.520 through M1450.550 below.*
- If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).*

M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

- A. Policy** *The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.*
- B. Personal Effects and Household Items** *A transfer of personal effects or household items does not affect eligibility. Personal effects and household items are:*
- an engagement ring;
 - a wedding ring;
 - items required by an individual's medical or physical condition; and
 - household goods and personal effects that are not items of unusual value.

An item of unusual value is:

- one that has a fair market value of more than \$1000 or
- two or more items, when each has a fair market value of \$500 or more.

NOTE: Transfer of an item of unusual value affects eligibility for payment of LTC services.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- A vehicle used by the applicant/recipient to obtain medical treatment.
- A vehicle used by the applicant/recipient for employment.
- A vehicle especially equipped for a disabled applicant or recipient.
- A vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, \$4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of \$4,500 must be evaluated as an asset transfer.

D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to \$6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is \$6,000 or less or
- \$360 if the equity is more than \$6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

E. Resources Under PASS

Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.

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| F. Certain Life Insurance | Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of \$1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future. |
| G. Certain Cash and In-kind Items | Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment. |
| H. Burial Spaces or Plots | Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment. |
| I. Excluded Burial Funds | Transfer of up to \$1,500 in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment. |
| J. Cash to Purchase Medical/Social Services | Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month. |
| K. Alaskan Natives' Stock | Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment. |
| L. Other Assets That Are Not Resources | <p>The transfer of the following resources, if they have been kept separate from other resources, do not affect eligibility for LTC services' payment:</p> <ul style="list-style-type: none"> • Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970. • Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance. • Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973. • Retroactive Supplemental Security Income and/or retroactive Social Security payments for <i>nine (9)</i> months after the month of receipt of the payment(s). • Retained disaster assistance. |

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

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| A. Policy | <p>If the transfer meets the criteria below in this section, the transfer does NOT affect eligibility for LTC services' payment.</p> <p>If the transfer does not meet the criteria in this section, see section M1450.500 below to evaluate the asset transfer.</p> |
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B. Home Property Transferred to Certain Individuals	Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.
1. Spouse, Minor Child, Disabled/Blind Child	<p>When the home property is transferred to the individual's</p> <ul style="list-style-type: none"> • spouse, • child(ren) under age 21 years, or • child(ren) of any age who is blind or disabled as defined by SSI or Medicaid, <p>the transfer does not affect eligibility.</p>
2. Sibling	<p>When the home property is transferred to the individual's sibling or half-sibling (not step-sibling) who</p> <ul style="list-style-type: none"> • has an equity interest in the home, and • who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual, <p>the transfer does not affect eligibility.</p>
3. Adult Child	<p>When the home property is transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and who meets the criteria listed in items a. through d. below, the transfer does not affect eligibility.</p>
a. Provided Care for 2 Years	<p>The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.</p>
b. Physician's Statement	<p>The individual or his/her representative must provide a statement from his/her treating physician which states</p> <ul style="list-style-type: none"> • the individual's physical and/or mental condition during this two-year period, • why the individual needed personal and/or home health care during this period, and • the specific personal/home health care service needs of the individual.
c. Statement of Services Provided	<p>The son or daughter must provide a statement showing:</p> <ol style="list-style-type: none"> 1) the specific services and care he/she provided to the individual during the entire two years; 2) how many hours per day he/she provided the service or care; 3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

- 4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

C. Transfer to Certain Individuals or Trusts

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
 - 1) child under age 21, or
 - 2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does **not affect** eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated

with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursement of funds to other beneficiaries provided that the trust does not permit such disbursements until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item 3 above, go to M1450.540 below to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

D. Intention to Receive Adequate Compensation

Transfer of any asset does not affect eligibility for LTC services' payment if the individual shows that he/she intended to receive adequate compensation for the asset or that he/she actually received adequate compensation for the asset for LTC services' payment. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below.

1. Evidence of Reasonable Effort to Sell The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. Burial Trust of \$2,500 or Less The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of \$2,500 or less and that the burial trust was established before July 1, 1988. The trust is adequate compensation for the transferred asset.

Thus, transfer of \$2,500 or less into an irrevocable burial trust before July 1, 1988, will not affect Medicaid payment for LTC services.

4. Burial Trust of Over \$2,500 The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of over \$2,500, and that the burial trust was established on or after July 1, 1988. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, 1120.201 and 1120.202.

E. Reason Exclusive of Becoming or Remaining Medicaid-Eligible

Transfer of any asset does not affect eligibility if the asset was transferred for a reason **exclusive** of becoming or remaining eligible for Medicaid LTC services' payment.

1. The individual must provide objective evidence that the transfer exclusively for another purpose(s) and the reason(s) for the transfer did not include possible or future Medicaid eligibility.
2. A subjective statement of intent or ignorance of the asset transfer provision is not sufficient. The individual could, for example, provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

- F. Post-Eligibility Transfers by the Community Spouse** Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.
- Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.*
- G. Purchase of an Annuity by Community Spouse** For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:
- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant;
 - the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child; and
 - if the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state is named as the beneficiary in the first position.
- H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to \$4,000** *The policy in this subsection applies to applications processed on or after July 1, 2006 to transfers made on or after February 8, 2006.*
- Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to \$1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.
- Assets transferred on or after February 8, 2006, that have a total cumulative value of more than \$1,000 but less than or equal to \$4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.
- I. Return of Asset** The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.
- J. Undue Hardship Policy** *Policy for claiming undue hardship was moved to M1450.570.*

M1450.500 ASSET TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

The transfer of an asset that is not listed in section M1450.300 above, affects the individual's eligibility for Medicaid payment of LTC services if the transfer does not meet one of the criteria in section M1450.400 above.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- personal effects or household items of unusual value,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500,
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity *before February 8, 2006*.
- *M1450.530 for a purchase of an annuity on or after February 8, 2006.*
- *M1450.540 for promissory notes, loans, or mortgages.*
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy**.

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

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|---|---|
| <p>2. Policy Funds Irrevocable Trust</p> | <p>Since an irrevocable trust for burial is not a pre-need funeral, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.</p> |
| <p>6. Determine If Transfer Is Uncompensated</p> | <p>When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:</p> <ol style="list-style-type: none"> a. Determine the benefit payable at death. The face value of the policy is the “benefit payable at death.” b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is “twice the premium.” c. Compare the result to the term insurance policy’s face value. <ol style="list-style-type: none"> 1) If the term insurance’s face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility. 2) If the term insurance’s face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or 630 below. |

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.520 PURCHASE OF ANNUITY *BEFORE FEBRUARY 8, 2006*

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

The following policy applies to annuities purchased before February 8, 2006. Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

C. Procedures

Determine if the annuity is actuarially sound:

1. Use the life expectancy tables in M1450, Appendix 2:
 - find the individual's age **at the time the annuity was purchased** in the "Age" column for the individual's gender ("Male" or "Female").
 - the corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.
2. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).
3. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.
4. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.

When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

EXAMPLE #2: A man at age 65 purchases a \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for LTC services payment.

EXAMPLE #3: A man at age 80 purchases the same \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

M1450.530 PURCHASE OF ANNUITY ON OR AFTER FEBRUARY 8, 2006

A. Introduction

*The DRA established new policy for evaluating the purchase of an annuity as an asset transfer. The policy applies to annuities purchased on or after February 8, 2006. A significant change made under the DRA is that annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. **The policy in this section applies to applications processed on or after July 1, 2006 to transfers made on or after February 8, 2006.***

B. Policy

- 1. An annuity purchased by the institutionalized individual or the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:*
 - the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant;*
 - the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child; and*
 - if the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state is named as the beneficiary in the first position.*
- 2. An annuity purchased by the institutionalized individual on or after February 8, 2006, will be considered an uncompensated transfer unless:*
 - the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:*
 - (b)-individual retirement account,*
 - (c)-accounts established by employers and certain association of employees, or*
 - (p)-simple retirement accounts*
 - a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or*
 - a Roth Individual Retirement Account (IRA).*
- 3. An annuity purchased by the institutionalized individual on or after February 8, 2006, will be considered an uncompensated transfer unless the annuity is:*
 - irrevocable and non-assignable;*
 - actuarially sound (see M1450.520.C);*
 - provides for equal payments with no deferral and no balloon payments.*

4. *A copy of the annuity agreement must be sent to:*

*DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219*

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction *This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.*

B. Policy *Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:*

- has a repayment term that is actuarially sound (see M1450.100),*
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and*
- prohibits the cancellation of the balance upon the death of the lender.*

C. Uncompensated Amount *If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.*

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

M1450.550 TRANSFERS INVOLVING TRUSTS

A. Introduction *A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.*

B. Revocable Trust

1. Transfer Into Revocable Trust *A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.*

2. Payments From a Revocable Trust *Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.*

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

**3. Look-back
Date**

The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses \$100 to Mr. B and \$500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. B's brother.

The \$100 and \$500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave \$50,000 away, the countable value of the trust is the remaining \$50,000. The transfer of the \$50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is \$50,000. The penalty date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust **MAY** be asset transfers for less than fair market value, depending on whether the terms of the trust

- allow for payments to or for the benefit of the individual, OR
- do not allow for payments to or for the benefit of the individual.

**1. When
Payment to
Individual Is
Allowed**

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

- a. the portion of the trust principal that could be paid to or for the benefit
- b. income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;
- c. payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;
- d. payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

- | | |
|---|--|
| <p>a. Transfer Into Trust</p> | <p>A transfer of assets into an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.</p> |
| <p>b. Payments From Trust</p> | <p>Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.</p> <p>Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.</p> <p>The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).</p> |
| <p>c. Look-back Date When Payment to Individual Is Allowed</p> | <p>The look-back date is 36 months for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.</p> <p>EXAMPLE #5: Mr. C established an irrevocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee disburses \$100 to Mr. C and \$500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. C's brother.</p> <p>The \$100 and \$500 payments are counted as income to Mr. C. Because the trustee gave \$50,000 away, the value of the trust is the remaining \$50,000. The \$50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the \$50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr. C is not eligible for Medicaid because the \$50,000 available trust resource exceeds the Medicaid resource limit.</p> |
- 2. When Payment to Individual Is NOT Allowed**
- When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

**a. Transfer
Into Trust**

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

- the date the trust was established.
- the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

**b. Payments
From Trust**

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

**c. Look-back
Date When
Payment to
Individual
Not Allowed**

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses \$100 to Mr. D and \$500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another \$10,000 of his savings into the trust.

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established (\$100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is \$100,000.

The 7-2-96 transfer of \$10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is \$10,000

M1450.560 INCOME TRANSFERS**A. Policy**

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 CLAIM OF UNDUE HARDSHIP**A. Definition**

Undue hardship exists when the application of the transfer of assets provisions would deprive the individual of medical care such that his health or his life would be endangered. Undue hardship also exists when the application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

B. Policy

When Medicaid eligibility is being determined for an individual requesting LTC who has transferred assets without adequate compensation as defined in M1450.003 D. and M1450.003 N., the individual must be informed that undue hardship can be claimed. The individual must provide written information to clearly document and substantiate:

- *that the resources transferred without adequate compensation cannot be recovered; and*

- *that the immediate adverse impact of the denial of Medicaid coverage of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter, or other necessities of life.*

The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12VAC30-110.

C. Procedures

1. *When the applicant or enrollee has made an uncompensated transfer, give the individual a copy of the Asset Transfer Hardship Claim Form (see M1450, Appendix 1). Any written request that clearly substantiates the hardship claim is also acceptable. If the individual does not wish to claim hardship, document the case record.*
2. *Retain a copy of the request for the record and send the undue hardship claim and supporting documents to DMAS at the following address:*

*DMAS, Division of Policy and Research, Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219*

3. *DMAS will notify the worker of the decision on the hardship claim. If the asset transfer must be considered, determine the penalty period using applicable policy in M1450.600 through M1450.640.*
4. *If a penalty period must be imposed, follow the procedures in M1450.700 through M1450.703 for notifying the applicant and DMAS of the action. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.*

M1450.600 PENALTY PERIOD DETERMINATION

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

The penalty period continues (it does not change or stop) when an institutionalized individual is discharged from long-term care. If the individual is re-admitted to LTC and the penalty period has not ended, Medicaid payment for LTC services will again be denied for the remainder of the penalty period.

**B. Determination
Procedures**

Determine the uncompensated value using policy and procedures in M1450.610 below. Then, go to M1450.620 *or* 630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE**A. Policy**

The uncompensated value of the transferred asset is the difference between

- the asset's fair market value at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the asset) and
- the amount received for the asset.

Determine the uncompensated value of the transferred asset in this section, go to M1450.620 *or* 630 to determine the penalty period.

**B. Term Life
Insurance Purchase
On or Before April
7, 1993**

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

**C. Term Life
Insurance Purchase
After April 7, 1993**

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used \$3,000 from his checking account to pay a \$3,000 premium on a \$5,000 face value term life insurance policy. On October 5, 1995, he used \$2,000 from his checking account to pay up premiums on the same \$5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is \$3,000. The uncompensated value of the second transfer on 10-5-95 is \$2,000. The penalty period for the first transfer is based on the \$3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the \$2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.
2. the result is the yearly payout amount.
3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.
4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).
5. multiply the uncompensated payout years by the yearly payout amount.
6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses \$9,000 from his savings account on May 6, 1996, to purchase a \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$$\begin{array}{r}
 \$10,000 \text{ annuity value} \\
 \div \underline{10} \text{ years life of annuity} \\
 \$1,000 \text{ yearly payout} \\
 \\
 10 \text{ years life of annuity} \\
 - \underline{6.98} \text{ life expectancy} \\
 3.02 \text{ uncompensated payout years} \\
 \times \underline{\$1,000} \text{ yearly payout} \\
 \$3,020 \text{ uncompensated value}
 \end{array}$$

The penalty period is based on the \$3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of \$100,000 on March 1, 1994. Each month, the trustee disburses \$100 to Mr. B and \$500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. B's brother.

The \$100 and \$500 payments are counted as income to Mr. B. The transfer of the \$50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is \$50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of \$100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal (\$100,000) could be disbursed to Mr. C under the terms of the trust. Each month, the trustee disburses \$100 to Mr. C and \$500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. C's brother.

The \$100 and \$500 payments are counted as income to Mr. C. The transfer of the \$50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is \$50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

**d. Example
#11**

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of \$100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses \$100 to Mr. D and \$500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave \$50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed (\$100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.

The uncompensated value is \$100,000. The fact that \$50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional \$25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this \$25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is \$25,000; the transfer date is 6-20-96.

G. Income Transfers

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a \$2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is \$2,000.

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the life expectancy tables in M1450, *Appendix 2*.

EXAMPLE #12: A man aged 65 years, assigns his right to a \$500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is \$89,760.

\$ 500
x12 months
\$6,000 yearly income
x14.96 life expectancy from table
\$89,760 value
- 0 compensation
\$89,760 uncompensated value

H. Other Asset Transfers

The uncompensated value of a transferred asset is the difference between the asset's fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset at the time of transfer) and the amount received for the asset.

1. From the fair market value, subtract the total of outstanding encumbrances against the asset at the time of transfer.
2. The result is the asset value at time of transfer.
3. Subtract the total compensation the individual received for the asset.
4. The result is the uncompensated value.

EXAMPLE #13: Mr. D receives Medicaid. On September 20, 1996, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1994, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at \$85,000 in August 1994. The mortgage against his home had a balance of \$10,000 in August 1994. He received \$1,000 from his nephew in return for the home.

The uncompensated value of the transferred asset is calculated:

\$85,000 assessed value
- 10,000 lien balance
75,000 equity
- 1,000 compensation received
\$ 74,000 uncompensated value

The penalty period is based on the uncompensated value of \$74,000 and the penalty date of September 1994.

M1450.620 PENALTY PERIOD FOR TRANSFERS *BEFORE FEBRUARY 8, 2006*

A. Policy

When a transfer of an asset *before February 8, 2006* affects eligibility, the penalty period during which Medicaid will not pay for long-term care services, begins with the penalty date, which is:

- for applicants, the first day of the month in which the asset was transferred;

- for recipients, the first day of the month **following** the month in which the asset was transferred.

However, if the individual meets all Medicaid eligibility requirements, the individual is eligible for Medicaid payment of all other covered services.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

The penalty period continues (it does not change or stop) when an institutionalized individual is discharged from long-term care. If the individual is re-admitted to LTC and the penalty period has not ended, Medicaid payment for LTC services will again be denied for the remainder of the penalty period.

B. Penalty Date

For applicants who are applying for Medicaid, the penalty date is **the first day of the month in which the asset transfer occurred** provided that date does not occur during an existing penalty period.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

C. Penalty Period Calculation

The penalty period is the number of months calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid**. Beginning 10-1-97, the average cost differs for individuals in Northern Region localities (see *M1450*, Appendix 3 for the list of localities in the Northern Region). The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid**.

See the chart below for the average private nursing facility cost for Northern Region localities and all other Virginia localities.

D. Average Monthly Private Nursing Facility Cost

Average Monthly Private Nursing Facility Cost*		
<u>Application Date</u>	<u>Northern Region</u>	<u>All Other Localities</u>
10-1-96 to 10-1-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 and after	\$5,403	\$4,060

*Figures provided by Virginia Health Information.

Contact a Medicaid Consultant for amounts prior to October 1, 1996.

E. One Transfer

1. Determine the penalty period:
 - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
 - round the result down;
 - the result is the number of months in the penalty period.
2. Determine the penalty date.
3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.
4. The last day of the last month in the penalty period is the end date of the penalty period.

EXAMPLE #14: Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on *October 1, 1996*. He is found eligible for retroactive and ongoing Medicaid. He remains eligible for Medicaid and remains living in his home.

On September 20, 1998, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1996, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at \$85,000 in August 1996. He received no compensation. The agency determines the transfer occurred within the 36 months prior to 9-20-98, the date Mr. D. was both institutionalized and a Medicaid recipient. The look-back date is September 20, 1995; the look-back period is September 20, 1995 through September 20, 1997. The transfer occurred after the look-back date. The agency evaluates the transfer and determines that the transfer affects eligibility because it does not meet any of the criteria in section M1450.300 and 400.

The agency must impose a penalty period. The uncompensated property value is \$85,000.

$$\begin{array}{r} \$85,000 \text{ assessed value} \\ \div 2,564 \text{ avg. cost NF care at time of his } 10-1-96 \text{ application} \\ \hline 33.15 \text{ rounded down to } 33 \end{array}$$

The penalty period based on the uncompensated value is 33 months. Because Mr. D is a recipient, the penalty date is September 1, 1996. The penalty period begins September 1, 1996 and ends *May 30, 1999*.

**F. Multiple Transfers
In Same Month**

When a number of assets are transferred within the **same month**, calculate the penalty period using the total value of all assets transferred in the month, divided by the average monthly private nursing facility cost.

**G. Multiple Transfers
Different Months**

When assets are transferred in **different months**, use the following procedures:

1. Calculate Each Penalty Period

Calculate the individual transfer penalty period for each month's transfer.

2. Penalty Periods Overlap

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, add together the value of all assets transferred and divide by the average monthly private nursing facility cost. This process produces a single penalty period which begins on the penalty date.

If the penalty periods overlap:

- add together the value of all assets transferred;
- divide by the average monthly private nursing facility cost;
- the result is a single penalty period which begins on the penalty date.

EXAMPLE #15: An individual transfers \$10,000 in January, \$10,000 in February and \$10,000 in March 1996, all of which are uncompensated. Medicaid application dated April 1996. Each penalty period is calculated individually:

$$\begin{array}{r} \$10,000 \text{ uncompensated value} \\ \div 2,554 \text{ average private NF cost at April 1996 application} \\ \hline 3.91 \text{ rounded down to 3 months penalty period for each} \\ \text{transfer} \end{array}$$

The penalty period for each transfer is 3 months. The first penalty period runs from 1-1-96 through 3-31-96. The second penalty period runs from 2-1-96 through 4-30-96. The third penalty period runs from 3-1-96 through 5-31-96. These periods overlap. The single penalty period is calculated:

$$\begin{array}{r} \$10,000 \\ +10,000 \\ +10,000 \\ \hline \$30,000 \text{ total amount transferred} \\ \div 2,554 \text{ average private NF cost at April 1996 application} \\ \hline 11.74 \text{ rounded down to 11 months penalty period} \end{array}$$

The single 11-month penalty period runs from the penalty date. Because this is an applicant, the penalty date is the first day of the month in which the first transfer occurred. The penalty period is 1-1-96 through 11-30-96.

3. Penalty Periods Do Not Overlap

When multiple asset transfers' penalty periods **do not overlap**, treat each transfer as a separate event with its own penalty period.

EXAMPLE #16: Mrs. E. entered a nursing facility on June 15, 1996, and applied for Medicaid on November 16, 1996. The agency is determining eligibility on December 16, 1996. She transferred \$10,000 to her son on June 12, 1996, \$10,000 to her daughter on September 13, 1996, and \$5,000 to a granddaughter on December 25, 1996, for a total of \$25,000.

The agency determines the transfers occurred after the look-back date of November 16, 1993, 36 months prior to the date Mrs. E. was both institutionalized and a Medicaid applicant, 11-16-96. The agency evaluates the transfers and determines that they affect eligibility because they occurred after the look-back date and they do not meet any of the criteria in section M1450.300 and 400.

Since the transfers all occurred before a penalty period had been imposed, the agency calculates each penalty period as follows:

$$\begin{array}{r} \$10,000 \text{ asset transferred} \\ \div 2,564 \text{ average private NF cost at 11-16-96 application} \\ \hline 3.90 \text{ rounded down to 3 months penalty period for each} \\ \$10,000 \text{ transfer} \end{array}$$

$$\begin{array}{r} \$5,000 \text{ asset transferred} \\ \div 2,564 \\ \hline 1.95 \text{ rounded down to 1 month} \end{array}$$

The penalty periods are:

June 1, 1996 through August 31, 1996 for the asset transferred 6-12-96.

September 1, 1996 through November 30, 1996 for the asset transferred 9-13-96.

December 1, 1996 through December 31, 1996 for the asset transferred 12-25-96.

Mrs. E. no longer has excess resources, and she is eligible for Medicaid beginning November 1, 1996. She is not eligible for Medicaid payment of LTC services in November and December 1996. Since the last penalty period ended on 12-31-96, she becomes eligible for Medicaid payment of long-term care services beginning January 1, 1997.

H. Transfers While In An Existing Penalty Period

When additional transfers for less than market value occur during an existing penalty period, recalculate the penalty period using the procedures in item G. above.

I. Transfers After A Penalty Period Ended

When a transfer for less than market value occurs after a penalty period has ended, calculate a new penalty period by dividing the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid, and round down. For applicants, the penalty date is the first day of the month in which the asset was transferred; for recipients, the penalty date is the first of the month following the month in which the asset was transferred.

EXAMPLE #17 - Mr. F. entered a nursing facility on June 13, 1996, and applied for Medicaid on October 14, 1996. When the agency evaluated his application, the worker learned that Mr. F. had transferred real estate assessed at \$10,000 on October 12, 1996. Since the transfer did not meet

any of the criteria in M1450.300 and 400, a penalty period for Medicaid payment of long-term care services was determined. The 3-month period ran from October 1, 1996, through December 31, 1996.

On March 10, 1997, while Mr. F. was receiving Medicaid, he disclaimed an inheritance of \$30,000. Since the disclaimer is a transfer that did not occur in another penalty period, the agency calculated a new penalty period. The penalty date is April 1, 1997, the first day of the month following March 1997, the month in which the transfer occurred. The new period is 11 months from April 1, 1997 through February 28, 1998. Therefore, Mr. F. was ineligible for Medicaid payment of long-term care services from October 1, 1996 through December 31, 1996, and is ineligible for Medicaid payment of long-term care services from April 1, 1997 through February 28, 1998

J. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by his/her spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. One of two actions may be taken by the couple:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A enters a nursing facility and applies for Medicaid. Mrs. A transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A still has 24 months to run. Because Mrs. A is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A decide to have the penalty period divided between them. Therefore, both Mr. A and Mrs. A are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A leaves the facility and is no longer institutionalized. Mrs. A remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A and 6 months for Mrs. A), must be imposed on Mrs. A. If Mr. A becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice

**M1450.630 PENALTY PERIOD FOR TRANSFERS ON OR AFTER
FEBRUARY 8, 2006**

A. Policy

The policy in this section applies to applications processed on or after July 1, 2006 for transfers made on or after February 8, 2006. The DRA enacted significant changes to the implementation date of the penalty period. When the transfer is made prior to the request for Medicaid LTC, the penalty period does not begin until the individual is eligible for Medicaid LTC. Penalty periods are assessed for fractional portions of a month. The number of months is not rounded down; therefore, the penalty period may end on a day during the month. .

B. Penalty Date

*When a transfer of an asset made on or after February 8, 2006, affects eligibility, the period of ineligibility for Medicaid payment for long-term care services, begins the **later** of:*

- the first day of the month during or after which assets have been transferred for less than fair market value; or*
- the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level of care but for the application of the penalty period; and*
- which does not occur in any other period of ineligibility imposed for any reason.*

However, if the individual meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

**C. Penalty Period
Calculation**

The penalty period is the number of months, including any fractional portion of a month, that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

**D. Average Monthly
Nursing Facility
Cost**

See M1450.620.D for the average monthly nursing facility cost for the locality in which the individual is physically located at the time of application for Medicaid.

**E. Partial Month
Transfer**

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: *An individual makes an uncompensated transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated transfer amount of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7 month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial*

penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

Step #1	\$30,534.00	uncompensated transfer amount
	$\div 4,060.00$	avg. monthly nursing facility rate at time of application
	= 7.52	penalty period (7 full months, plus a partial month)
Step #2	\$4,060.00	avg. monthly nursing facility rate at time of application
	$\times 7$	seven-month penalty period
	\$28,420.00	penalty amount for seven full months
Step #3	\$30,534.00	uncompensated transfer amount
	$-28,420.00$	penalty amount for seven full months
	\$2,114.00	partial month penalty amount
Step #4	\$2,114.00	partial penalty amount
	$\div 130.97$	daily rate (\$4,060 \div 31)
	= 16.14	number of days for partial month penalty

For October 2006, the partial month penalty of 16 days would be added to the seven (7) month penalty period. The means that Medicaid would authorize payment for LTC services beginning November 17, 2006.

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. M1450.620.J contains instructions for apportioning the penalty period.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

**B. Example #20 -
Full Compensation
Received**

Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth \$30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling \$30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G.'s eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

**C. Example #21
Partial
Compensation
Received**

Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H.'s Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H.'s son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004 and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 AGENCY ACTION

A. Policy

If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.

B. Procedures

The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.701, 702, and 703 below.

M1450.710 APPLICANT/RECIPIENT NOTICE

- A. Policy** Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.
- B. Notice Contents** The Notification of Action on Medicaid sent to the individual must specify:
- the individual is eligible for Medicaid beginning (the appropriate date) and
 - Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
 - the penalty period may be shortened if compensation is received.
- C. Advance Notice** When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:
- the individual is eligible for Medicaid.
 - Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
 - the penalty period may be shortened if compensation is received.

M1450.720 PROVIDER NOTICE

- A. Introduction** Use the DMAS-122 to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.
- B. DMAS-122** The DMAS-122 form includes:
- the individual's full name, Medicaid number, and social security number;
 - the individual's birth date;
 - the patient's Medicaid coverage begin date;
 - the patient's income;
 - no deductions or patient pay amounts; and

- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.730 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-122 sent to the provider.

B. Copy of DMAS-122

The copy of the DMAS-122 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-122:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

The agency worker *must* send a copy of the DMAS-122 to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services, Suite 1300
600 E. Broad St.
Richmond, VA 23219.

The copy of the DMAS-122 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

ASSET TRANSFER HARDSHIP CLAIM FORM

TO: _____

Agency Name: _____
Case Name: _____
Case #: _____
Worker #: _____

If you wish to claim that an Undue Hardship would result if you were ineligible for Medicaid payment of nursing facility services or community-based care (CBC) waiver services, check the first box below, attach copies of any necessary documentation and sign and date where indicated.

If you do not wish to claim an Undue Hardship, check the second box, sign your name and the date where indicated below the second box.

_____ I want to claim Undue Hardship.

Please provide information about the following:

- 1) What you transferred and the date of transfer;
- 2) The value at the time of transfer and what you received;
- 3) Why you transferred the asset(s);
- 4) What other assets you had at the time of transfer;
- 5) Was legal action taken to recover the asset? If not, why not?
- 6) Can you get the asset back? If not, why not?
- 7) The impact if you are not eligible for Medicaid payment of your long-term care services; including the loss of medical care that could endanger your life or the loss of food, clothing, shelter or other necessities of life.

Your explanation will be evaluated by *the Department of Medical Assistance Services*. You will be notified in writing of the decision that is made.

I affirm that the information provided about my claim for an Undue Hardship is true and correct to the best of my knowledge and belief.

Signature of Claimant or Authorized Representative

Date

_____ I do not want to claim hardship. My right to claim hardship has been explained to me and I choose not to claim a hardship.

Signature of Claimant or Authorized Representative

Date

LIFE EXPECTANCY TABLES**A. Life Expectancy Table - Males**

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

B. Life Expectancy Table - Females

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

LOCALITIES in the NORTHERN REGION

For the determination of asset transfer penalty periods, the localities in the Northern Region are:

Counties:

Arlington

Fairfax

Loudoun

Prince William

Cities:

Alexandria

Fairfax

Falls Church

Manassas

Manassas Park

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10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of “old bills” are treated as old bills even though they are not the individual’s liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual’s countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

*The policy in this section applies to nursing facility and CBC patients who meet the requirements for LTC on or after January 1, 2006. It does **not** apply to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.*

1. Approved for LTC Before 01-01-2006

*If a Medicaid enrollee was approved for LTC **before** January 1, 2006, do not evaluate substantial home equity at the next renewal. As long as he remains continuously eligible for Medicaid, do not evaluate substantial home equity.*

If the enrollee is found ineligible for Medicaid, and he subsequently re-applies for Medicaid LTC, substantial home equity must be evaluated when he re-applies.

2. Approved for LTC On/After 01-01-2006

If a Medicaid enrollee was approved for LTC on or after January 1, 2006 but before July 1, 2006, evaluate substantial home equity at the next renewal.

If a Medicaid applicant or enrollee was approved for LTC on or after July 1, 2006, the substantial home equity must be evaluated immediately and appropriate action taken if the individual has substantial home equity.

B. Policy

*Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds \$500,000 are **NOT** eligible for Medicaid payment of long-term care services unless the home is occupied by*

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Reverse Mortgages

*Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.*

2. Home Equity Credit Lines

*A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.*

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding \$500,000, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for Long Term Care Services

The covered groups whose benefit packages include long-term care services are the following groups:

- a. All categorically needy (CN) covered groups.
- b. All categorically needy non-money payment (CNNMP) covered groups.
- c. ABD with income \leq 80% FPL (ABD 80% FPL).
- d. All medically indigent (MI) Families & Children (F&C) covered groups:
 - pregnant women and newborns under age 1 year,
 - children under age 19.
- e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:
 - ICF-MR services,
 - IMD services,
 - MR Waiver services, and
 - DD Waiver services.

**2. Applicants
Who Do Not
Receive Cash
Assistance**

a. Child Under Age 19

If the applicant is a child under age 19, first determine the child's eligibility as an MI child, using the covered group policy in M0320 and the financial eligibility policy in chapters M05 and M07. If not eligible as MI, determine the child's eligibility in the CNNMP 300% SSI group, using the covered group policy in subchapter M0320 and the financial eligibility policy and procedures in this subchapter.

If the child's resources or income exceed the limits for the 300% SSI group, determine the child's eligibility in an MN covered group (subchapter M0330).

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 19 or Older

If the applicant is an individual age 19 or older, determine the individual's eligibility in the ABD or F&C covered group depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the 300% SSI covered group. If not eligible in the 300% SSI covered group, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the MN (see M0330) and the limited benefit ABD MI (see M0320) covered groups.

For F&C individuals, first determine the individual's eligibility in the CNNMP 300% SSI group. If the individual's income exceeds the limits for 300% SSI covered group, determine the individual's eligibility in an MN covered group (see M0330).

**B. Relation to Income
Limits**

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. 300% SSI

The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in "Countable Income for the 300% SSI Group," section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in "What Is Not Income," section M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

2. ABD 80% FPL

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in "What Is Not Income," Section M1460.610 and in "Countable Income for the 300% SSI Group," Section M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

3. **ABD MN Groups** The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

4. **F&C MI and MN Groups** The F&C income policy in chapter M07 is used to determine countable income for individuals in F&C MI and MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MI and MN groups.

C. Ongoing Recipient Enters LTC

1. **Cash Assistance Recipients** Recipients who are already enrolled in Medicaid when they enter Medicaid long-term care and who receive cash assistance payments must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.
2. **Other Recipients** Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

D. Covered Groups

The financial eligibility rules for each covered group are contained in the following sections:

1. **SSI Recipients** SSI recipients' financial eligibility requirements are in section M1460.201 below.
2. **Other CN Groups** Other categorically needy groups are listed in section M1460.210 below.
3. **CNNMP Groups** CNNMP groups are listed in section M1460.220 below
4. **ABD 80% FPL** An ABD 80% FPL recipient's financial eligibility requirements are in section M1460.225 below.

5. **MN Groups** Medically needy (MN) groups are listed in section M1460.230 below.

6. **MI Groups** MI groups are listed in section M1460.240 below.

M1460.201 SSI RECIPIENTS

A. Introduction

An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. *An SSI recipient is income-eligible for LTC as long as he is entitled to an SSI payment. When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.* The covered group eligibility requirements for SSI recipients are in section M0320.201.

1. Medicaid CBC

An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility

SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of \$30 for their personal needs. If they have other countable income that exceeds \$30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

Determine if the SSI recipient has the following real property resource(s):

- 1) equity in non-exempt property contiguous to his home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 2) interest in undivided heir property and the equity value of *the individual's* share *that*, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the

estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in section M1120.215);

- 3) ownership (equity value) of *the individual's* former residence *when* the SSI recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;
- 4) equity value in property owned jointly *by the SSI recipient and* another person *who is not the SSI recipient's spouse*, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) *previously*, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources for an assistance unit of 1 person.

When an SSI recipient has no real property resource listed in 1) through 5) previously, do NOT evaluate the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a countable real property resource listed above.

b. Countable Resources Within Resource Limit

If countable resources are less than or equal to the \$2,000 resource limit, go to item 4 below for income eligibility.

c. Countable Resources Exceed the Resource Limit

If current resources exceed the \$2,000 resource limit, the individual is NOT eligible in the SSI recipient covered group, nor is he eligible in the 300% SSI group or the medically needy group. He may be eligible for limited Medicaid coverage as medically indigent (which has more liberal resource methods and standards), however, Medicaid will not pay for LTC services for an ABD medically indigent recipient.

4. Income

An SSI recipient in LTC is income-eligible for Medicaid as long as he receives an SSI payment. Verify receipt of the payment. If the SSI recipient meets the nonfinancial and resource eligibility rules for Medicaid, then he is eligible for Medicaid as categorically needy.

- a. When an SSI recipient who has no other income enters a nursing facility, the SSI check is usually reduced to \$30 for the month following the month of entry. The SSI payment is **NOT** counted as income when determining income eligibility or patient pay.

- b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.210 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

- 1. **QSII (1619(b))** Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.
- 2. **AG Recipients** An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

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- 27. Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
- 28. Spouse** means a person who is legally married to another person under Virginia law.
- 29. Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability *The policy in this section applies to nursing facility and CBC patients who meet the requirements for LTC on or after January 1, 2006. The policy does not apply to recipients approved for LTC prior to January 1, 2006 who maintain continuous Medicaid eligibility.*

1. Approved for LTC Before 01-01-2006 *If the enrollee's eligibility for LTC was approved **before** January 1, 2006, do not apply this policy at the next renewal of Medicaid eligibility. If the individual becomes ineligible for Medicaid and subsequently re-applies for Medicaid LTC, the substantial home equity policy must be evaluated when determining Medicaid eligibility based on the new application.*

2. Approved for LTC On/After 01-01-2006 *If the enrollee's eligibility for LTC was approved **on or after** January 1, 2006, **but before July 1, 2006**, apply this policy at the next renewal of Medicaid eligibility.*

*If the enrollee's eligibility for LTC was approved **on or after** January 1, 2006, and eligibility is processed **on or after July 1, 2006**, apply this policy immediately. Take appropriate action if the individual is ineligible for Medicaid payment of LTC because of substantial home equity.*

B. Policy *Individuals with equity value in home property that exceeds \$500,000 are **NOT** eligible for Medicaid payment of long-term care (LTC) services unless the home is occupied by:*

- *a spouse,*
- *a dependent child under age 21 years, or*
- *a blind or disabled child of any age.*

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Reverse Mortgages *Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.*

- 2. Home Equity Lines of Credit** *A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received*
- B. Verification Required** *Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.*
- C. Notice Requirement** *If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding \$500,000, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.*
- D. References** *See section M1120.225 for more information about reverse mortgages.*

M1480.020 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

- A. Policy** Federal Law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. However, on occasion it is difficult to comply with this requirement because the applicant is unable to establish his marital status, locate the separated spouse or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:
1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse; and (b) that he has been unsuccessful in doing so;

Absent extraordinary circumstances, determined by DMAS, the requirements of A.1.(a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.
 2. Upon such investigation as DMAS may undertake, no facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.
 3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
 4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the file.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services and the possibility of a request for an expected contribution.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment and determine an expected contribution, document the file.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of “community spouse” is not met, and we do not consider his/her resources.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed:

If the applicant does not wish to claim undue hardship, the EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims undue hardship, he must provide documentation of efforts made to obtain the needed information. Claims of undue hardship must be evaluated and can only be granted by DMAS. The EW must send a summary of the needed information and documentation of the attempts made to secure the information, along with the applicant’s name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed. The EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines undue hardship exists, the EW will be sent instructions for continued processing of the case as well as the DMAS AFFIDAVIT and ASSIGNMENT forms which the applicant must sign, have notarized and return to the agency.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

A resource assessment must be completed when a married institutionalized individual with a community spouse

- is in a nursing facility,

- is screened and approved to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

applies for Medicaid. The spousal share is used in determining the institutionalized individual's resource eligibility.

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The \$2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:**

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and

- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name. If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionalization

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

8. Notification Requirements**a. When the Assessment Is Not Completed**

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION**A. Introduction**

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy**1. Resource Assessment**

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:**

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;

- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month** of the first continuous period of institutionalization,
- *all reported countable resources owned by the couple on the first moment of the first day of the month of application, and*
- *all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.*

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Use the Medicaid Resource Assessment form (#032-03-816) to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization.

**2. Send Loans
and/or
Judgments to
DMAS**

When the resource assessment or eligibility determination identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**3. Determining
the First
Continuous
Period of
Institutional-
ization**

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

**4. Failure to
Provide
Verification**

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

requested data, the worker is unable to complete the resource assessment and the application must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

**5. Completing
the Medicaid
Resource
Assessment**

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to $\frac{1}{2}$ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

institutionalization) were \$131,000. The spousal share is ½ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$31,000

\$131,000 Total Value of Couple's Countable Resources

\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources *owned as of the first moment of the first day of the month for which eligibility is being determined* and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, regardless of the individual's covered group and regardless of community property laws or division of marital property laws,

except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- *the home and **all** contiguous property;*
- *one automobile, regardless of value;*
- *Disaster Relief funds for 9 months;*
- *retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and*
- *up to **\$3,500** of burial funds for each spouse.*

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

**2. After Eligibility
is Established**

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

**C. "Institutionalized
Spouse Resource
Eligibility
Worksheet"**

Use the "Institutionalized Spouse Resource Eligibility Worksheet" to determine the institutionalized spouse's resource eligibility. The worksheet is in Appendix 4 to this subchapter.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

**B. Spousal Resource
Standard**

\$19,908 1-1-06

\$19,020 1-1-05

**C. Maximum Spousal
Resource
Standard**

\$99,540 1-1-06

\$95,100 1-1-05

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid *if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined* and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources *owned as of the first moment of the first day of the month for which eligibility is being determined.*

B. Procedures

Use the following criteria to determine Medicaid eligibility for *any month in the initial eligibility determination period.*

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources *owned as of the first moment of the first day of the month for which eligibility is being determined.*

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for

review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**2. Deduct
Spousal
Protected
Resource
Amount (PRA)**

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources *owned as of the first moment of the first day of the month for which eligibility is being determined*. The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is \$0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order**;
- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months) and all subsequent Medicaid applications.

**3. Compare
Remainder**

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit, the individual is not eligible for Medicaid because of excess resources. Go to section M1480.250 below.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month *for which eligibility is being determined*:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.242 below.

**C. Example--Using the
“Institutionalized
Spouse Resource
Eligibility
Worksheet” To
Calculate the PRA**

EXAMPLE #4: (The “Worksheet” is in Appendix 4 to this subchapter)

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. *Eligibility is being determined for December 1997.*

Step 1: The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

Step 2: $\$130,000 \div 2 = 65,000$. The spousal share is \$65,000.

Step 3: The couple's total countable resources *as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*, are \$67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$65,000 (the spousal share, which is less than the maximum spousal resource standard of \$79,020 in December 1997, the time of application).
- \$15,804 (the spousal resource standard in December 1997, the time of the application).
- \$0 (court-ordered spousal support resource amount or DMAS hearing decision amount; there is neither in this case).

Since \$65,000 is the greatest, \$65,000 is the PRA.

Step 5: *Deduct the PRA from the couple's combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined).*

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
- 65,000	Step 4 PRA
\$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

The remaining \$2,000 is the countable resources available to the institutionalized spouse *on December 1, 1997 (the first moment of the first month for which eligibility is being determined)*.

Step 6:

Compare the \$2,000 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in December *(the month for which eligibility is being determined)*. A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support

EXAMPLE #5: Mr. B applied for Medicaid on January 2, 1998. He was admitted to a nursing facility on December 20, 1996. He is married to Mrs. B who lives in their community home. This is Mr. B's first application for Medicaid as an institutionalized spouse. The court ordered him to transfer \$68,000 of his resources to Mrs. B as spousal support; he transferred \$68,000 to her on December 5, 1997. *Mr. B. is not requesting retroactive coverage.*

Step 1:

The couple's total countable resources as of December 1, 1996 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

Step 2:

$\$130,000 \div 2 = \$65,000$. The spousal share is \$65,000.

Step 3:

The couple's total *countable* resources as of January 1, 1998 *(the first moment of the first day of the month for which eligibility is being determined)* are \$67,000.

Step 4:

Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$65,000 (the spousal share, which is less than the maximum spousal resource standard of \$80,760 in the application month);
- \$16,152 (the spousal resource standard at the time of the application);
- \$68,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- \$0 DMAS hearing decision amount (there is none in this case).

Since \$68,000 is the greatest, \$68,000 is the PRA.

Step 5:

Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined).

:

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 68,000	Step 4 PRA
\$ 0	countable resources in month for which eligibility is being determined (January 1, 1998).

\$0 is the countable resources available to the institutionalized spouse for January (*the month for which eligibility is being determined*).

Steps 6 & 7:

Compare the \$0 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so he is resource-eligible for January (*month for which eligibility is being determined*). He is also income eligible in January, so Mr. B establishes initial eligibility in January 1998.

For February and the following months, his eligibility is determined using just his resources. Beginning February (*the month following the month eligibility is established*), none of the community spouse's resources are deemed available to Mr. B. Because his own resources equal \$0, he remains resource eligible in the months following the application month.

E. Example--Support Order Greater Than Amount Transferred & Institutionalized Spouse's Actual Resources

EXAMPLE #6: Mrs. Green applied for Medicaid on May 2, 1998. She was admitted to a nursing facility on June 20, 1997. She is married to Mr. Green who lives in their community home. This is Mrs. Green's first application for Medicaid as an institutionalized spouse. The first moment of the first day of the first continuous period of institutionalization is June 1, 1997. The couple's total resources on June 1, 1997 were \$110,000. \$30,000 were in Mr. Green's name; \$80,000 were in Mrs. Green's name. On December 7, 1997, the court ordered her to transfer \$180,000 of her resources to Mr. Green as spousal support. However, Mrs. Green's resources were only \$80,000. She transferred \$80,000 to Mr. Green on December 20, 1997. *Eligibility is being determined for May 1998.*

Step 1:

The couple's total countable resources as of June 1, 1997 (the first moment of the first day of the first continuous period of institutionalization) were \$110,000.

Step 2:

$\$110,000 \div 2 = \$55,000$. The spousal share is \$55,000.

Step 3:

The couple's total *countable resources as of the May 1, 1998 (first moment of the first day of the month for which eligibility is being determined)* are \$100,000 (all are in Mr. Green's name).

Step 4:

Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$55,000 (the spousal share, which is less than the maximum spousal resource standard of \$80,760 in the application month);
- \$16,152 (the spousal resource standard at the time of the application);
- \$80,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- \$ 0 DMAS hearing decision amount (there is none in this case).

Since \$80,000 is the greatest, \$80,000 is the PRA.

Step 5:

Deduct the PRA from the couple's combined countable resources as of May 1, 1998 (the first moment of the first day of the month for which eligibility is being determined).

\$100,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,000	Step 4 PRA
\$20,000	countable resources in month for which eligibility is being determined.

\$20,000 is the countable resources available to the institutionalized spouse, in May 1998 (the month for which eligibility is being determined).

Steps 6 & 7:

Compare the \$20,000 countable resources to the resource limit of \$2,000. *Mrs. Green's countable resources exceed the resource limit in the month for which eligibility is being determined (May 1, 1998).* Her application is denied because of excess resources. She and Mr. Green are notified of the denial action and the resource calculations upon which it is based.

F. PRA Revisions Policy

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.
2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.
3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above.
4. The agency determines that inaccurate information was provided when the agency calculated the spousal share and determined the PRA for the initial eligibility determination. The agency must revise the calculations using the correct information.

G. Example--DMAS Hearing Officer Revised PRA

EXAMPLE #7: Mr. C applied for Medicaid on November 21, 1996. He was admitted to a nursing facility on December 20, 1994. This is his first application for Medicaid as an institutionalized spouse. He is married to Mrs. C who lives in their community home. The first moment of the first day of the first month of the first continuous period of institutionalization is December 1, 1994. *Mr. C is not resource eligible in the retroactive period. Eligibility is being determined for November 1996.* The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were \$150,000.

Step 2:

$\$150,000 \div 2 = \$75,000$. The spousal share is \$75,000.

Step 3: The couple's total *countable* resources on November 1, 1996 (*first moment of the first day of the month for which eligibility is being determined*) are \$80,000.

Step 4: *Determine the spousal protected resource amount (PRA).* The spousal PRA is the greatest of:

\$75,000 (the spousal share, which is less than the maximum spousal resource standard of \$76,740 in November 1996);

Step 5: *Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined).*

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
\$ 5,000	countable resources in month for which eligibility is being determined.

\$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the \$5,000 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for Medicaid in *November 1996 (the month for which eligibility is being determined)*. He is not a QMB, so his application was denied in January 1997 because of excess resources.

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs.

After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of \$76,740 should be the PRA. Mr. C's eligibility was recalculated using the \$76,740 PRA.

Step 5 again: The revised PRA was deducted from the couple's total combined countable resources in *November 1996 (the initial month for which eligibility is being determined)*:

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740	Step 4 PRA
\$3,260	countable resources in month for which eligibility is being determined.

\$3,260 is the countable resources available to Mr. C in *November 1996 (the month for which eligibility is being determined)*. Because he has excess resources, and because he is not a QMB (has no Medicare Part A), he is not eligible for Medicaid and the denial was sustained.

M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**. Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
- Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**.

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

1. **Couple's Resources** Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**
 2. **Subtract PRA** Subtract the spousal PRA (M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.
 3. **Countable Resources Within Limit** If the countable resources in a *retroactive* month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.
 4. **Countable Resources Exceed Limit** If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.
- D. Retroactive Example** **EXAMPLE #8:** Mr B's first continuous period of institutionalization began on 9-20-92. He **first applied for Medicaid on February 3, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

Retroactive Month *December 1997*

Step 1: The couple's total resources as of September 1, 1992 (*the first moment of the first day of the first continuous period of institutionalization*) were \$200,000.

Step 2: $\$200,000 \div 2 = \$100,000$. The spousal share is \$100,000.

Step 3: The couple's total *countable* resources *as of December 1, 1997 (the retroactive month for which eligibility is being determined)* are \$96,000.

Step 4: *Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:*

- \$80,760 (the maximum spousal resource standard *in effect at the time of application (February 20, 1998)* is less than the spousal share of \$100,000);
- \$16,152 (the spousal resource standard *in effect at the time of application (February 20, 1998)*),
- \$0 (no amount designated by DMAS Hearing Officer),
- \$0 (no amount transferred pursuant to court support order).

The PRA is \$80,760 (*the lesser of the maximum resource standard and the spousal resource standard, because there was no amount designated by DMAS Hearing Officer or transferred per court order*).

NOTE: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

Step 5: Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)

\$96,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,760	Step 4 PRA
\$15,240	countable resources in month for which eligibility is being determined.

\$15,240 countable to Mr. B.

Step 6: Since \$15,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid for December 1997 (the retroactive month for which eligibility is being determined).

Complete a retroactive determination for January 1998.

Retroactive Month January 1998

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were \$200,000.

Step 2: $\$200,000 \div 2 = \$100,000$. The spousal share is \$100,000.

Step 3: The couple's total countable resources as of January 1, 1998 (the retroactive month for which eligibility is being determined) are \$93,000.

Step 4: Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

The PRA is \$80,760 (See Step 4 in the retroactive determination for December 1997 above).

Step 5: Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

\$93,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,760	Step 4 PRA
\$12,240	countable resources in month for which eligibility is being determined.

\$12,240 countable resources for Mr. B.

Step 6: Since \$12,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid in for January 1998 (the retroactive month for which eligibility is being determined). Proceed to determine eligibility for the initial eligibility determination period that begins with February 1998 (month of application).

**Initial Eligibility
Determination
Month**

February 1998

- Step 1:** The couple's total resources as of September 1, 1992 (*the first moment of the first day of the first continuous period of institutionalization*) were \$200,000.
- Step 2:** $\$200,000 \div 2 = \$100,000$. The spousal share is \$100,000.
- Step 3:** The couple's total *countable* resources as of February 1, 1998 (*the month for which eligibility is being determined*) are \$90,000.
- Step 4:** Determine the PRA: *Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.*
- The PRA is \$80,760 (*See Step 4 in the retroactive determine for December 1997 above*).
- Step 5:** *Deduct the PRA from the couple's combined countable resources on February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*
- | | |
|----------|--|
| \$90,000 | Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined |
| - 80,760 | Step 4 PRA |
| \$9,240 | countable resources in month for which eligibility is being determined. |
- \$ 9,240 countable resources for Mr. B.
- Step 6:** Since \$9,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid in February 1998 (*the month for which eligibility is being determined*).

Note: The initial eligibility determination period continues until the individual is found eligible. If Mr. B reapplies, he will still be in the initial eligibility determination period.

M1480.240 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Purpose of the CSRA

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including his share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. The purpose of the community spouse resource allowance (CSRA) is to protect resources that are in the institutionalized spouse's name for the community spouse's support.

The CSRA is the amount of the institutionalized spouse's resources that are disregarded during the protected period. The protected period of eligibility is the time frame during which the institutionalized spouse is allowed to transfer resources to the community spouse.

B. Introduction

The CSRA only applies to an institutionalized spouse who began a continuous period of institutionalization on or after 9-30-89 and has been found eligible for Medicaid because his countable resources are less than the resource limit. If the continuous period of institutionalization began before 9-30-89, do not use the CSRA policy.

After determining the initial month's eligibility for the institutionalized, determine:

- what resources are in the community spouse's name as *of the first moment of the first day of the initial month for which eligibility was established*,
- what resources are in the institutionalized spouse's name as *of the first moment of the first day of the initial month for which eligibility was established*. If the **institutionalized spouse's** resources have changed since the initial month's eligibility determination, verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month for which eligibility was determined.
- how much of the institutionalized spouse's resources can be transferred to the community spouse to bring the community spouse's resources up to the PRA.

The institutionalized spouse's resource eligibility is "protected" for 90 days to allow him to transfer resources to the community spouse.

For the month in which initial eligibility is established, determine resources as a couple. In subsequent months, **do not deem or count any of the community spouse's resources to the institutionalized spouse.** During the "protected period" of 90 days, do not count the resources in the institutionalized spouse's name which were "disregarded" as the community spouse's protected resource amount (PRA). At the end of the protected period of 90 days, all resources in the institutionalized spouse's name must be counted available to the institutionalized spouse.

C. Policy

Beginning the *first moment of the first day of the calendar month following the month in which initial eligibility is established*, **only the resources owned in the institutionalized spouse's name (including jointly owned resources) are considered when determining his eligibility.** The resources owned in the community spouse's name are no longer considered available to the institutionalized spouse.

1. First Application

This subsection applies to an individual applying for Medicaid as an institutionalized spouse for the first time and *who has established eligibility in the initial eligibility determination period.*

a. Not Eligible In Initial Eligibility Determination Period

If the institutionalized spouse is NOT eligible after deducting the spousal PRA from the couple's total resources, DO NOT USE this section. Go to section M1480.250 below when resources exceed the limit.

b. Eligible In the Initial Eligibility Determination Period

When the institutionalized spouse's countable resources (as calculated in section M1480.232 above) are within the Medicaid resource limit, calculate the CSRA using the policy and procedures in section M1480.241.

2. Subsequent Application**a. Medicaid Eligibility Never Established**

If an individual has applied before but never established Medicaid eligibility as an institutionalized spouse and is NOT eligible in the initial eligibility determination period, DO NOT USE THIS SECTION. Go to section M1480.250 below.

b. Medicaid Eligibility Established Previously

Once an institutionalized spouse has established *initial* eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

When determining the institutionalized spouse's eligibility based on any application made after having previously established Medicaid eligibility as an institutionalized individual, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do NOT consider the couple's resources.** Use only the institutionalized spouse's resources in the application month and the application's retroactive month(s). **Do not calculate a CSRA; there is no protected period of eligibility. Go to section M1480.255 below.**

M1480.241 CSRA CALCULATION PROCEDURES**A. Worksheet**

Use the "Institutionalized Spouse Resource Eligibility Worksheet" (Appendix 4 to this subchapter) to determine countable resources and the CSRA.

B. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources *owned as of the first moment of the first day of the initial month for which eligibility was established.*

C. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources *owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized*

spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month.

D. Calculate the Community Spouse Resource Allowance (CSRA)

To calculate the CSRA:

1. PRA

Find the spousal PRA (determined in section M1480.232 above).

2. Subtract Resources

Subtract the community spouse's owned as of the first moment of the first day of the initial month in which eligibility was established.

3. Remainder

The remainder, if greater than zero, is the CSRA (community spouse resource allowance).

If the remainder is \$0 or a negative number, the CSRA = \$0. The community spouse does not have a CSRA.

E. Subtract the CSRA

Find the CSRA calculated in D above.

Subtract the CSRA from the **institutionalized spouse's** resources *owned effective the first moment of the first day of the initial month in which initial eligibility is established.*

The remainder is the institutionalized spouse's countable resources for the month **following the initial month in which eligibility is established.**

F. Countable Resources Less Than or Equal To the Resource Limit

If the countable resources are less than or equal to the Medicaid resource limit, the institutionalized spouse remains eligible for a protected period of time **IF** he expresses **in writing** the intent to transfer an amount of his resources, equal to the CSRA, to the community spouse. See section M1480.242 below.

G. Countable Resources Exceed Resource Limit

If the countable resources exceed the Medicaid resource limit, the institutionalized spouse is not eligible for Medicaid; deny eligibility for the months following the initial month in which eligibility is established. Go to section M1480.250 below.

H. Example--CSRA Calculation

EXAMPLE #9: Mrs. Tea applied for Medicaid on May 21, 1998. She was admitted to the nursing facility on December 20, 1997. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1997. *Eligibility is being determined for May 1998.*

Step 1:

The couple's total countable resources as of December 1, 1997 (*the first moment of the first day of the first continuous period of institutionalization*) were \$50,000.

- Step 2:** \$50,000 ÷ 2 = \$25,000. The spousal share is \$25,000.
- Step 3:** The couple's total *countable* resources *as of May 1, 1998 (the initial month for which eligibility is being determined)* are \$26,500.
- Step 4:** *Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:*
- | | |
|----------|--|
| \$25,000 | (the spousal share, which is less than the maximum spousal resource standard of \$80,760 in effect at the time application). |
| \$16,152 | (the spousal resource standard on effect at the time of the application). |
| \$0 | amount transferred as court-ordered spousal support |
| \$0 | DMAS hearing decision amount. |
- Since \$25,000 is the greatest, \$25,000 (the spousal share) is the PRA.
- Step 5:** *Deduct the PRA from the couple's combined countable resources on May 1, 1998 (the first moment of the first day of the month for which eligibility is being determined)*
- | | |
|----------|---|
| \$26,500 | Step 3 couple's total <i>resources owned as of first moment of the first day of the month for which eligibility is being determined</i> |
| - 25,000 | Step 4 PRA |
| \$ 1,500 | countable resources <i>in month for which eligibility is being determined.</i> |
- \$1,500 is the countable resources available to Mrs. Tea, the institutionalized spouse, in the *month for which eligibility is being determined.*
- Steps 6 & 7:** Compare the \$1,500 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource eligible for Medicaid May 1998 (month for which eligibility is being *determined*).
- Step 8a:** *Effective the first moment of the first day of the initial month for which eligibility is established,* the community spouse owns in his name only \$6,000 of the couple's total countable resources, and ½ of the couple's \$2,000 joint savings account; his share = \$1,000. The community spouse's available resources total \$7,000.
- Step 8b:** *Effective the first moment of the first day of the month for which eligibility is established,* the institutionalized spouse owns, in her name only, \$18,500 of the couple's total countable resources, and owns ½ of the couple's \$2,000 joint savings account; her share = \$1,000. The institutionalized spouse's resources total \$19,500 *on the first moment of the first day of the month for which eligibility is established.*

Step 9: The CSRA is calculated:

\$25,000 Step 4 PRA
 - 7,000 Step 8a community spouse's available resources
 \$18,000 CSRA

Step 10: \$19,500 Step 8b institutionalized spouse's resources in *June (month following the month in which eligibility was established)*
 - 18,000 Step 9 CSRA
 \$ 1,500 institutionalized spouse's countable resources in June

Steps 11 & 12: Because \$1,500 is *less than* the \$2,000 resource limit, Mrs. Tea's resource eligibility in the month following *the initial month in which eligibility was established* is "protected" for up to 90 days if she states her intent in writing to transfer the amount of her resources which exceeds the \$2,000 limit (\$17,500) to Mr. Tea.

I. When Couple's Total Resources Are Less Than the Spousal Resource Standard
 When the couple's total resources are less than the spousal resource standard, the calculated CSRA will exceed the amount of the institutionalized spouse's resources. Even though the CSRA exceeds the institutionalized spouse's resources, the CSRA remains as calculated to allow a protected period of eligibility should the institutionalized spouse acquire additional resources during the protected period. If the institutionalized spouse acquires additional resources during the protected period, his eligibility is protected for the remainder of the period to allow him time to transfer resources to the community spouse.

Example: **EXAMPLE #10:** Mrs. T applied for Medicaid on November 21, 1997. She was admitted to the nursing facility on December 20, 1996. She is married to Mr. T who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1996. *Eligibility is being determined for November 1997.*

Step 1: The couple's total countable resources as of December 1, 1996 (*the first moment of the first day of the first continuous period of institutionalization*) were \$25,000.

Step 2: $\$25,000 \div 2 = \$12,500$. The spousal share is \$12,500.

Step 3: The couple's total *countable* resources as of November 1, 1997 (*the first moment of the first of the month for which eligibility is being determined*) are \$12,000.

Step 4: *Determine the spousal protected resource amount (PRA).* The spousal PRA is the greatest of:

- \$12,500 (the spousal share, which is less than the maximum spousal resource standard of \$79,020 in effect *at the time of application*);
- \$15,804 (the spousal resource standard at the time of the application);

- \$0 (amount actually transferred as court-ordered spousal support);
or
- \$0 (DMAS hearing decision amount).

Since \$15,804 is the greatest, \$15,804 (the spousal resource standard) is the PRA.

Step 5:

Deduct the PRA from the couple's combined countable resources on December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)

\$12,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 15,804	Step 4 PRA
\$ 0	countable resources in month for which eligibility is being determined (-\$3,804 difference)

\$0 is the countable resources available to Mrs. T, the institutionalized spouse, in the month for which eligibility is being determined.

Steps 6 & 7:

Compare the \$0 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource-eligible for Medicaid in the month for which eligibility is being determined.

Step 8a:

The community spouse owns, in his name only, \$6,000 of the couple's total countable resources as of the first moment of the first day of the month for which eligibility was established, and ½ of the couple's \$2,000 joint savings account; his share = \$1,000. The community spouse's available resources total \$7,000.

Step 8b:

The institutionalized spouse owns, in her name only, \$4,000 of the couple's total countable resources as of the first moment of the first day of the month for which eligibility was established, and owns ½ of the couple's \$2,000 joint savings account; her share = \$1,000. The institutionalized spouse's available resources total \$5,000.

Step 9:

The CSRA is calculated:

\$15,804	Step 4 PRA
- 7,000	Step 8a community spouse's available resources
\$8,804	CSRA

Step 10:

\$5,000	Step 8b institutionalized spouse's resources
- 8,804	Step 9 CSRA
\$ 0	institutionalized spouse's countable resources

Steps 11 & 12:

Because \$0 is less than the \$2,000 limit, Mrs. T's resource eligibility in the months following the month in which eligibility was established can be "protected" for up to 90 days if she states, in writing, her intent to transfer the

amount of her resources (\$3,000) which exceeds the \$2,000 resource limit to Mr. T. The institutionalized spouse can transfer to the community spouse an amount of resources up to the amount of the CSRA. If Mrs. T receives additional resources of \$3,804 or less within the 90 days, she can remain eligible if she transfers the additional resources to her spouse before the 90-day protected period expires.

M1480.242 PROTECTED PERIOD OF ELIGIBILITY

A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time IF he has expressly indicated in writing his intent to transfer resources to his community spouse. The protected period, not to exceed 90 days, is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse.

During the protected period, resource eligibility is determined by subtracting the community spouse resource allowance (CSRA) from the institutionalized spouse's own resources. The CSRA is subtracted only during the protected period of eligibility.

Resources in the institutionalized spouse's name are excluded only in the amount of the CSRA and only for one 90-day period. If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a CSRA is NOT subtracted from his resources.

B. When A Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when

- the institutionalized spouse is not eligible for Medicaid;
- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid;
- at the time of application, a community spouse has title to resources equal to or exceeding the PRA (the calculated CSRA is \$0); or
- the eligible institutionalized spouse does NOT express his intent to transfer assets to the community spouse.

In these circumstances, an institutionalized spouse may transfer resources in any amount to the community spouse according to the Medicaid asset transfer policy, **but there will be no protected period of eligibility for doing so.**

- C. Intent to Transfer Resources To Community Spouse**
- To be entitled to the protected period of eligibility, the institutionalized spouse (or the institutionalized spouse's guardian or conservator, or the institutionalized spouse's attorney-in-fact who has the power to dispose of the institutionalized spouse's resources) must expressly indicate **in writing** his intention to transfer resources to the community spouse. Use the form "Intent to Transfer Assets to A Community Spouse" (Appendix 5 to this subchapter) to record the institutionalized spouse's intent to transfer resources to the community spouse.
- When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.
- There is no protected period of eligibility when the institutionalized spouse does NOT expressly indicate his intention to transfer resources to the community spouse. Deny (cancel) Medicaid eligibility for the months following the initial eligibility determination period. Since the institutionalized spouse is eligible for Medicaid in the initial eligibility determination period only, his Medicaid must be canceled effective the last day of the last month in the initial eligibility determination period. Use eligibility Type 4 to enroll the institutionalized spouse for the initial eligibility determination period only.
- D. How to Determine the Protected Period**
- The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his guardian, conservator or attorney-in-fact expressly indicates his intent to transfer resources to the community spouse.
- 1. Applicant**
- An individual who was not receiving Medicaid prior to the initial eligibility determination is allowed a protected period of 90 days from the date eligibility is approved, if he has expressed intent to transfer resources to the community spouse.
- 2. Recipient**
- An individual who is receiving Medicaid at the time he became an institutionalized spouse must have his eligibility reviewed. He is allowed a protected period of 90 days from the date his eligibility is redetermined, if he has expressed the intent to transfer resources to the community spouse.
- E. Protected Period Ends**
- Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.
- F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility**
- If the **institutionalized spouse** obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:
- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR

- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the CSRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

**1. Determine
CSRA Balance**

The CSRA balance is the CSRA less the amount of resources actually transferred to the community spouse after initial eligibility was established. If the institutionalized spouse acquires additional resources during the protected period, the CSRA balance is the amount which can be excluded from the institutionalized spouse's countable resources for the remainder of the protected period.

**2. Determine
Countable
Resources**

- Total the institutionalized spouse's countable resources in the month in which the new resource was received.
- Subtract the CSRA balance.
- The remainder is the value of his countable resources in the month.

**3. Countable
Resources
Exceed the
Resource
Limit**

If the institutionalized spouse has excess resources after acquiring new resources during the protected period, he is ineligible for the month of receipt and subsequent month(s). Take appropriate action to cancel Medicaid, and refer the case to the Department of Medical Assistance Services (DMAS) for recovery of Medicaid payments made in the months in which the institutionalized spouse had excess resources.

NOTE: If the institutionalized spouse transfers or reduces his resources to the resource limit within the month of receipt of the new resources, reinstate his Medicaid coverage. Be sure to determine if the resource transfer or reduction meets the asset transfer policy in subchapter M1450.

**4. Example--
Additional
Resources
Acquired**

EXAMPLE #11: Mr. Frost applied for Medicaid on January 2, 1998. He was admitted to the nursing facility on December 20, 1995. He is married to Mrs. Frost who lives in an Adult Care Residence (ACR). This is his first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1995. The court ordered him to transfer \$68,000 of his resources to Mrs. Frost as spousal support; he transferred \$68,000 to her on December 5, 1997. *Eligibility is being determined for January 1998.*

Step 1:

The couple's total countable resources as of December 1, 1995 (*the first moment of the first day of the first continuous period of institutionalization*) were \$130,000.

Step 2:

$\$130,000 \div 2 = \$65,000$. The spousal share is \$65,000.

Step 3: The couple's total *countable* resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined) are \$67,000.

Step 4 Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$65,000 the spousal share, which is the less than the maximum spousal resource standard of \$80,760 in effect at the time of application.
- \$16,152 the spousal resource standard at the time of application.
- \$68,000 amount transferred as court-ordered spousal support.
- \$0 DMAS hearing decision amount (there is none in this case).

Since \$68,000 is the greatest, \$68,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined):

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 68,000	Step 4 PRA
\$ 0	countable resources in the month for which eligibility is being determined

\$0 is the countable resources available to the institutionalized spouse in the application month.

Steps 6 & 7: Compare the \$0 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so he is resource-eligible in the application month. On February 21, the worker determines that he is resource and income eligible in the application month, so he establishes initial eligibility in January 1998. For the 90 days following February 21, his resource eligibility is determined using just his resources and deducting the CSRA because he stated in writing his intent to transfer any excess resources to his community spouse.

Step 8a: The community spouse owns, in her name only, \$60,000 of the couple's total countable resources, and ½ of the couple's \$7,000 joint savings account; her share = \$3,500. The community spouse's available resources total \$63,500.

Step 8b: The institutionalized spouse owns, in his name only, none of the couple's total countable resources at the time of application, and owns ½ of the couple's \$7,000 joint savings account; his share = \$3,500. The institutionalized spouse's available resources total \$3,500.

Step 9: The CSRA is calculated:

$$\begin{array}{r} \$68,000 \text{ Step 4 PRA} \\ - \underline{63,500} \text{ Step 8a community spouse's available resources} \\ \$4,500 \text{ CSRA} \end{array}$$

Step 10:
$$\begin{array}{r} \$3,500 \text{ Step 8b institutionalized spouse's resources} \\ - \underline{4,500} \text{ Step 9 CSRA} \\ \$ 0 \text{ institutionalized spouse's resources} \end{array}$$

Steps 11 & 12: Because \$0 is less than the \$2,000 limit, Mr. Frost's resource eligibility in the months following the initial eligibility determination period is "protected" for up to 90 days because he stated his intent to transfer his excess resources to Mrs. Frost. He must transfer at least \$1,500 of his resources to Mrs. Frost to remain eligible after the protected period.

On February 20, 1998, Mr. Frost received an inheritance of \$10,000 (income in February, the month of receipt). He transferred \$3,000 of his resources to Mrs. Frost on February 21. \$10,500 remained in his own name as of March 1. March is still within the protected period. Therefore, his countable resources for March are calculated:

$$\begin{array}{r} \$10,500 \text{ institutionalized spouse's resources March 1} \\ - \underline{1,500} \text{ CSRA balance } (\$4,500 - 3,000 \text{ transferred} = \$1,500) \\ \$ 9,000 \text{ countable resources in March} \end{array}$$

Mr. Frost is not eligible for Medicaid beginning March 1 because of excess resources. The agency is processing the application and change on February 21. The worker enrolls Mr. Frost in Medicaid for the period January 1 - February 28, and sends him a notice of this limited coverage period with the reminder to reapply for Medicaid when his resources are reduced to \$2,000 or less.

Mr. Frost transfers \$8,500 to Mrs. Frost on April 27, 1998 and reapplies for Medicaid on April 28, 1998. Mrs. Frost's resources are not considered. Mr. Frost's resources total \$2,000 on April 28, 1998. Because his resources are within the limit on April 28, he is eligible for Medicaid beginning April 1, 1998. He is not eligible for March 1998 because he had excess resources in March.

**5. Example--
Resources
Acquired
During
Protected
Period, Within
Limit**

EXAMPLE #12: Mrs. Tree applied for Medicaid on November 21, 1997. She was admitted to the nursing facility on July 20, 1995. She is married to Mr. Tree who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is July 1, 1995. *Eligibility is being determined for November 1997.*

Step 1: The couple's total countable resources as of July 1, 1995 (*the first moment of the first day of the first continuous period of institutionalization*) were \$25,000.

Step 2: $\$25,000 \div 2 = \$12,500$. The spousal share is \$12,500.

Step 3: The couple's total *countable* resources as of November 1, 1997 (the first moment of the first day of the month for which eligibility is being determined) are \$12,000.

Step 4: Deduct the PRA from the couple's combined countable resources as of November 1, 1997 (the first moment of the first day of the month for which eligibility is being determined):

- \$12,500 the spousal share, which is less than the maximum spousal resource standard of \$79,020 in the application month.
- \$15,804 the spousal resource standard at the time of the application).
- \$0 amount transferred as court-ordered spousal support
- \$0 DMAS hearing decision amount.

Since \$15,804 is the greatest, \$15,804 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources on as of November 1, 1997 (the first moment of the first day of the month for which eligibility is being determined):

\$12,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 15,804	Step 4 PRA
\$ 0	countable resources in the month for which eligibility is being determined.

\$0 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the \$0 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource-eligible for Medicaid in the month for which eligibility is being determined.

Step 8a: The community spouse owns, in his name only, \$6,000 of the couple's total countable resources at the time of application and ½ of the couple's \$2,000 joint savings account; his share = \$1,000. The community spouse's available resources total \$7,000.

Step 8b: The institutionalized spouse owns, in her name only, \$4,000 of the couple's total countable resources at the time of application and owns ½ of the couple's \$2,000 joint savings account; her share = \$1,000. The institutionalized spouse's available resources total \$5,000.

Step 9: The CSRA is calculated:

\$15,804	Step 4 PRA
- 7,000	Step 8a community spouse's available resources
\$8,804	CSRA

Step 10: \$5,000 Step 8b institutionalized spouse's resources
 - 8,804 Step 9 CSRA
 \$ 0 institutionalized spouse's resources

Steps 11 & 12: \$0 is less than the \$2,000 resource limit. Mrs. Tree's resource eligibility in the months following the application month is "protected" for up to 90 days from the initial eligibility determination which was made on January 15, 1998, because she stated in writing her intent to transfer resources to her community spouse.

On February 2, 1998, Mrs. Tree transferred \$5,000 to Mr. Tree, leaving her \$0 resources. On February 9, Mrs. Tree received an inheritance of \$5,000. \$5,000 remained in her own name as of March 1, 1998. March is still within the protected period. Her countable resources for March are calculated:

 \$5,000 institutionalized spouse's resources in March
 - 3,804 CSRA balance (\$8,804 CSRA - 5,000 transferred = 3,804)
 \$ 1,196 countable resources in March

Because the new resources that Mrs. Tree received plus all other resources in her name, less the CSRA balance, do not exceed the resource limit, her Medicaid eligibility continues until April 15, 1998, the end of the protected period. All of Mrs. Tree's resources will be counted available to her beginning April 16, 1998, the day after the protected period ends.

- G. Community Spouse Acquires Additional Resources During Protected Period** If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**
- H. Reviewing Resource Eligibility** When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.
- I. Asset Transfers** Instructions for treatment of asset transfers are found in subchapter M1450.
- J. Example-- Re-application, No Protected Period** **EXAMPLE #13:** Mr. Apple is institutionalized in a nursing facility; he was admitted on January 28, 1998. Mrs. Apple is his community spouse. The first day of the first month of the first continuous period of institutionalization is January 1, 1998. Mr. Apple applied for Medicaid on February 5, 1998. *Eligibility is being determined for February 1998.*

Step 1: The couple's total resources on January 1, 1998 (*the first moment of the first day of the first continuous period of institutionalization*) were \$86,640.

Step 2: $\$86,640 \div 2 = \$43,320$. The spousal share is \$43,320.

Step 3: The couple's total *countable* resources as of February 1, 1998 (*the first moment of the first day of the month for which eligibility is being determined*) are \$45,320.

Step 4: Determine the spousal protected resource amount (PRA). It is the greater of:

- \$43,320 the spousal share which is less than the maximum spousal resource standard of \$80,760 at application,
- \$16,152 the spousal resource standard at application,
- \$0 amount designated by DMAS Hearing Officer,
\$0 amount transferred pursuant to court support order

\$43,320 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

\$45,320	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 43,320	Step 4 PRA
\$2,000	countable resources in the month for which eligibility is being determined.

Steps 6 & 7: Mr. Apple's resources equal the resource limit, so he is resource eligible. Since his income is within the Medicaid income limit, he is eligible for Medicaid in the application month.

Step 8: Mrs. Apple owns \$20,000, in her name only, plus \$8,320 (one-half share of jointly owned resources); a total of \$28,320 of the couple's resources is available to Mrs. Apple.

Step 8a: Mr. Apple's resources at application were \$8,680 in his name only and ½ the jointly owned account of \$16,640, or \$8,320. Total = \$17,000.

Step 9: Because Mr. Apple is eligible in the February 1998 application month, the community spouse resource allowance (CSRA) is calculated to determine Mr. Apple's ongoing eligibility:

\$43,320	PRA
- 28,320	community spouse's resources
\$15,000	CSRA

Step 10:

\$17,000	institutionalized spouse's resources
- 15,000	CSRA
2,000	countable resources

Steps 11 & 12: Mr. Apple's resources equal the limit and he remains eligible because he expressed, in writing, his intention to transfer his excess resources to Mrs. Apple. His resource eligibility is protected for 90 days beginning February 25, 1998, the date the agency took action to approve the application, and ending May 24, 1998.

- Review:** The day the protected period ends, May 24, 1998, the worker reviews Mr. Apple's resource eligibility and finds that Mr. Apple has not transferred all of the resources out of his name. His resources as of May 25, 1998 total \$15,000. The protected period of eligibility was over on May 24, so the CSRA is no longer subtracted from his resources. Because his resources exceed the \$2,000 resource limit, his Medicaid is canceled effective June 30, 1998 (cannot cancel on May 31 because of 10-day advance notice period requirement).
- Re-application:** Mr. A reapplies for Medicaid on August 9, 1998 and requests retroactive coverage for July 1998. He is still institutionalized. Because he had previously established Medicaid eligibility as an institutionalized spouse, only **his** resources are considered in determining his eligibility. His resources on July 1, 1998 and throughout August 1998 were \$3,000. Because \$3,000 exceeds the resource limit, he is not eligible retroactively for July 1998 and he is not eligible in August 1998 because his resources did not go below the limit in August. Because he already had a protected period of eligibility based on his previous Medicaid application, **the CSRA and protected period policy do not apply**. His August 1998 application is denied because of excess resources.

M1480.250 WHEN RESOURCES EXCEED THE RESOURCE LIMIT

A. Introduction

When the institutionalized spouse is not eligible because of excess resources, the institutionalized spouse is not eligible for any Medicaid coverage if he does not have Medicare Part A. Deny the application because of excess resources.

If he has Medicare Part A, the institutionalized spouse may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different.

B. Individual Has Medicare Part A

If the institutionalized spouse has Medicare Part A, evaluate eligibility for QMB, SLMB or QI using the same resource calculation but comparing the institutionalized spouse's countable resources to the higher QMB/SLMB/QI resource limit. The institutionalized spouse cannot be eligible for QDWI Medicaid because the resource requirements and resource limits are the same as MN; the institutionalized spouse has excess resources for QDWI Medicaid. [Section 1924(a)(1)].

If the countable resources are within the QMB/SLMB/QI limit for one person, the institutionalized spouse is resource-eligible for QMB, SLMB or QI. Determine countable income.

1. QMB Eligible

If countable income is within the QMB limit, the institutionalized spouse is eligible for limited QMB Medicaid. However, the only LTC service that Medicaid will cover for a QMB is the Medicare coinsurance for skilled nursing facility (SNF) care when the SNF care is covered by Medicare.

2. SLMB or QI Eligible

If income exceeds the QMB limit but is within the SLMB or QI limit, the institutionalized spouse is eligible for limited SLMB or QI Medicaid. Medicaid will not cover any of the cost of any LTC services for an SLMB *or*

QI recipient. Medicaid will only pay the recipient's Medicare Part B premium for an SLMB or QI.

3. Notice

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of:

- the denial of Medicaid eligibility for LTC services' payment because of resources over the \$2,000 Medicaid resource limit;
- when **QMB eligible**, approval of limited QMB Medicaid coverage which will only pay: Medicare premiums, Medicare deductibles and Medicare coinsurance; or
- when **SLMB or QI eligible**, approval of limited Medicaid coverage which will only pay (all or part of) the Medicare Part B premium; Medicaid will **not** pay for any medical services.

C. Individual Does Not Have Medicare Part A

If the institutionalized spouse does not have Medicare Part A, deny the Medicaid application because of excess resources.

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of the denial of Medicaid eligibility because of resources over the \$2,000 Medicaid resource limit.

D. Resources Reduced

An institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the \$2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.

M1480.255 RE-APPLICATION AFTER ELIGIBILITY CANCELED

A. Policy

When an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, then had Medicaid coverage canceled and then reapplies for Medicaid, do not consider the couple's resources. **Use only the institutionalized spouse's resources.**

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

B. Example—Re-application After Initial Eligibility Established, Then Canceled

EXAMPLE #14: Mr B's first continuous period of institutionalization began on 9-20-92. His current continuous period of institutionalization began on 11-12-96. He first applied for Medicaid on February 20, 1998. Mrs. B is his community spouse. All but \$500 of the couple's resources are in Mrs. B's name. *Eligibility is being determined for February 1998.*

Step 1:

The couple's total resources as of September 1, 1992 (*the first moment of the first day of the first continuous period of institutionalization*) were \$100,000.

Step 2: \$100,000 ÷ 2 = \$50,000. The spousal share is \$50,000.

Step 3: The couple's total *countable* resources as of *the first moment of the first month for which eligibility is being determined (February 1, 1998)* are \$51,000.

Step 4: *Determine the spousal protected resource amount (PRA). The PRA is the greatest of:*

- \$50,000 the spousal share, which is less than the \$80,760 maximum spousal resource standard at application;
- \$16,152 the spousal resource standard at application,
- \$0 amount designated by DMAS Hearing Officer,
\$0 amount transferred pursuant to court support order.

The PRA is \$50,000.

Step 5: *Deduct the PRA from the couple's combined countable resources on as of February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*

\$51,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 50,000	Step 4 PRA
\$ 1,000	countable resources in month for which eligibility is being determined.

Step 6: Since \$1,000 is less than the \$2,000 resource limit, Mr. B is resource-eligible for Medicaid in February 1998, the application month. Because \$50,500 of the couple's total resources are in Mrs. B's name, the PRA does not exceed the resources in the community spouse's name and Mrs. B has no CSRA. Mr. B continues eligible in the months following the application month because his resources are less than the \$2,000 limit.

On May 3, 1998, Mr. B begins receiving income which makes his income exceed the income limit. Mr. B's Medicaid coverage is canceled effective May 31, 1998, and he is placed on a spenddown for June 1998. He must reapply for Medicaid if he wants his eligibility determined again.

Re-application: Mr. B reapplies for Medicaid on December 6, 1998. He does not request retroactive coverage. He is still in the same period of institutionalization that began 11-12-96. This is NOT an initial eligibility determination because he established Medicaid eligibility as an institutionalized spouse in February 1998. Therefore, only Mr. B's resources are considered when determining his eligibility based on his new Medicaid application. His resources total \$900, so he is resource-eligible.

When the worker asked Mrs. B if she had transferred or given away any money, she reported that she gave some money to their son. The agency determines that the asset transfer does not affect Mr. B's eligibility for Medicaid payment of LTC services because the amount transferred was less than the average cost of nursing facility care at the time of transfer. Mr. B's income exceeds the limit and his application is denied because of excess income. He is placed on a spenddown.

M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

who are enrolled in ongoing Medicaid coverage and
whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MI Resource Limit

If the recipient's resources are less than or equal to the higher ABD MI resource limit, determine if the recipient's income is less than or equal to the QMB, SLMB or QI income limit (the recipient's resources exceed the QDWI resource limit, which is the same as the Medicaid resource limit).

- 1) When the recipient's income is less than or equal to the QMB, SLMB or QI income limit:
 - a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full coverage to limited coverage (specify the appropriate QMB, SLMB or QI coverage). Write a note on the notice telling the recipient that:
 - the limited (QMB, SLMB or QI) coverage will NOT pay for long-term care services, and
 - if he verifies that his resources are less than or equal to the \$2,000 resource limit, he should request reinstatement of full Medicaid coverage.
 - b) cancel the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using a QMB-only PD.
- 2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MI Resource Limit

If resources are greater than the ABD MI resource limit, follow the procedures in *item 2* below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid coverage. Specify the effective date, which is the last day of the month in

which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the \$2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

b. Cancel Medicaid Coverage

Cancel the recipient's coverage in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

**1. When
Applicable**

The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.

**2. When Not
Applicable**

If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

- a. income paid to one spouse belongs to that spouse;
- b. each spouse owns one-half of all income paid to both spouses jointly;
- c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];
- d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

- a. Income is considered available to each spouse as provided in the trust.
- b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:
 - 1) Income paid to one spouse belongs to that spouse.
 - 2) One-half income paid to both spouses shall be considered available to each spouse.
 - 3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any. If the community spouse is not entitled to a monthly income allowance from the institutionalized spouse, the community spouse may have an expected contribution to the institutionalized spouse. See Appendix 6 to this subchapter to determine the community spouse's expected contribution.

**4. Income
Determination**

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

**5. Post-eligibility
Treatment of
Income**

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

**M1480.310 300% SSI AND ABD 80% FPL INCOME ELIGIBILITY
DETERMINATION**

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered group.

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

B. 300% SSI Group

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

**2. Income Less
Than or Equal
to 300% SSI
Limit**

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CNNMP PD and determine patient pay according to the policy and procedures found in section M1480.400.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP dual-eligible QMB *aid category* (AC):

- Aged = 022
- Blind = 042
- Disabled = 062

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP non-QMB AC:

- Aged = 020
- Blind = 040
- Disabled = 060

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CNNMP AC:

- Aged = 020
- Blind = 040
- Disabled = 060

Enroll the F&C recipient with the appropriate CNNMP AC:

- Institutionalized child under age 21 = 082
- Institutionalized F&C individual age 21 or older = 060.

**3. Income
Exceeds 300%
SSI Limit**

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's gross income is less than or equal to the 80% FPL income limit, enroll the individual in the MMIS with the appropriate ABD 80% FPL PD and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

Procedures

- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
- 2. Aid Category**
 - a. If the institutionalized spouse does NOT have Medicare Part A:**

Aged = 018
Blind = 038
Disabled = 058
Child Under 21 in ICF/ICF-MR = 098
Child Under Age 18 = 088
Juvenile Justice Child = 085
Foster Care/Adoption Assistance Child = 086
Pregnant Woman = 097
 - b. If the institutionalized spouse has Medicare Part A:**

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

 - 1) When income is less than or equal to the QMB limit, enroll using the following ACs:

Aged = 028
Blind = 048
Disabled = 068
 - 2) When income is greater than the QMB limit, enroll using the following ACs:

Aged = 018
Blind = 038
Disabled = 058
- 3. Patient Pay** Determine patient pay according to section M1480.400 below.
- 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- | | | | |
|---|------------|-----------------------------|---------|
| B. Monthly Maintenance Needs Standard | \$1,650.00 | 7-1-06 | |
| | \$1,603.75 | 7-1-05 | |
| C. Maximum Monthly Maintenance Needs Allowance | \$2,488.50 | 1-1-06 | |
| | \$2,377.50 | 1-1-05 | |
| D. Excess Shelter Standard | \$495.00 | 7-1-06 | |
| | \$481.13 | 7-1-05 | |
| E. Utility Standard Deduction (Food Stamps) | \$253 | 1 - 3 household members | 2-1-06 |
| | \$317 | 4 or more household members | 2-1-06 |
| | \$227 | 1 - 3 household members | 10-1-05 |
| | \$282 | 4 or more household members | 10-1-05 |

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

- B. What Is Patient Pay** The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.
- C. Dependent Allowances** A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.
- D. Home Maintenance Deduction** A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:
- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
 - the institutionalized spouse still needs to maintain their former home.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

- A. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.
- B. Subtract Allowable Deductions** **If the patient has no patient pay income, he has no patient pay deductions.**
- When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.
- personal needs or maintenance allowance,
 - community spouse monthly income allowance,
 - family member's income allowance,
 - noncovered medical expenses.
 - home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care**a. Basic Allowance**

Deduct the \$30 basic allowance.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

- the patient has a legally appointed guardian and/or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

- the first \$75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of \$190 per month.

The special earnings allowance cannot exceed \$190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of \$875 per month. His special earnings allowance is calculated first:

programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files. Income verification *no older than 6 months old may* be used unless the agency has reason to believe it is no longer accurate. *It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.*

When the recipient has reported that he has no income (\$0 income), the recipient must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the recipient has reported \$0 income.

The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

When an ongoing F&C Medicaid recipient applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

The recipient is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.

**2. Medicaid
Renewal Form
Required**

When a Medicaid Renewal form is required, the form must be sent to the recipient no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the recipient to sign and return or can be mailed to the recipient for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the recipient has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

**C. Special
Requirements for
Certain Covered
Groups**

**1. Pregnant
Woman**

A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Cancel her coverage as a pregnant woman effective the last day

of the month in which the 60th day following the end of her pregnancy occurs. Reinstate coverage in the Family Planning Services (FPS) limited-coverage group effective the first day of the following month unless information available to the agency establishes her eligibility in a full-benefit covered group. Do not use change transactions to move an individual between full and limited coverage

2. FPS Review Requirements

The Medicaid eligibility of women in the FPS covered group must be evaluated 12 months following the **end of the pregnancy**. *This includes the month in which the pregnancy ended and the 60-day post-pregnancy period for pregnant women covered groups. Example: Pregnancy ended on July 13, 2006, the date the baby was born. The twelfth month from July 2006 (including July) is June 2007. The woman is not enrolled in FPS until October 1, 2006, because she received full coverage in AC 091 through September 30, 2006. MMIS calculates her maximum FPS eligibility period (24 months from pregnancy end date, including the month the pregnancy ended) and enters an end date of June 30, 2008. Her FPS eligibility must be redetermined before the June 2007 cutoff.*

At the time of renewal, if the woman is eligible in a full-benefit covered group, cancel her FPS coverage in the MMIS using cancel code "008" effective the last day of the month prior to the month the full coverage begins. Reinstate full coverage beginning the first day of the following month.

If the woman is eligible only for FPS, she remains enrolled in FPS for the remainder of the maximum FPS eligibility period as long as her eligibility continues. Income and other changes reported after the twelfth month from the end of the pregnancy must be evaluated to determine if she remains eligible for FPS.

For example, if her income goes above the 133% FPL limit after the twelfth month from the pregnancy end date, she is no longer eligible for FPS regardless of the end date of the FPS coverage period in MMIS. If action is taken before cutoff of the FPS end month indicated in MMIS, her FPS coverage must be canceled in MMIS using the appropriate cancel reason code, and she must be sent advance notice of the cancellation.

3. Newborn Child Turns Age 1

An application for a child enrolled as a Newborn Child Under Age 1 must be filed before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- verification of citizenship and identity
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

4. Child Under Age 19 (FAMIS Plus)

Eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled *FAMIS Plus* child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-

day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is *reinstated* in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS.

If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage.

**5. FAMIS Plus
Child Turns
Age 19**

When a *FAMIS Plus* child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

**6. Child Turns
Age 21**

When a recipient who is enrolled as a child under age 21 attains age 21, determine if the recipient meets the definition for another covered

**7. IV-E FC and AA
and Special
Medical Needs
AA Children
From Another
State**

For FC or AA children placed by another state's social services agency, verification of continued IV-E or non-IV-E special medical needs status, current address, and TPL can be obtained from agency records, the parent or the other state.

**8. Breast and
Cervical
Cancer
Prevention and
Treatment Act
(BCCPTA)**

The BCCPTA Redetermination, form #032-03-653, is used to redetermine eligibility for the BCCPTA covered group. The renewal form is available on-line at

<http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/general/032-03-653.pdf>. The recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

**9. SSI and QSII
(1619(b))
Covered Group
Recipients**

For recipients enrolled in the SSI and QSII Medicaid covered groups, the *ex parte* renewal consists of verification of continued SSI or 1619(b) status by inquiring SVES. If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**D. Recipient Becomes
Institutionalized**

When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.

E. LTC

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 (see Appendix 5 to subchapter M1410) for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.

Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

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M1550.000 DMHMRSAS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction The Department of Social Services' Division of Benefit Programs has *five* eligibility workers, called Medicaid Technicians, located in *four* Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (*LDSS*) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.

B. Procedures This subchapter contains a list and a brief description of the DMHMRSAS facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a DMHMRSAS facility (M1550.400).

M1550.200 DMHMRSAS FACILITIES

A. Introduction Three types of medical facilities are administered by DMHMRSAS: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. Training Centers Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.

Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

The State training centers *and locations* are:

- Central Virginia Training Center (*CVTC*) – *Madison Heights*
- Southside Virginia Training Center (*SSVTC*) – Petersburg
- Northern Virginia Training Center (*NVTC*) – Fairfax
- Southeastern Virginia Training Center (*SEVTC*) – Chesapeake
- Southwestern Virginia Training Center (*SWVTC*) – Hillsville

2. Psychiatric Hospitals Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

Patients in psychiatric hospitals may be Medicaid eligible only if they are

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they *meet* all non-financial and financial Medicaid eligibility requirements.

The following are psychiatric hospitals, offering differing levels of care:

- a. Eastern State Hospital – Williamsburg
- b. Central State Hospital – Petersburg
- c. Western State Hospital – Staunton
- d. Northern Virginia Mental Health Institute – Falls Church
- e. Southern Virginia Mental Health Institute – Danville
- f. Southwestern Virginia Mental Health Institute – Marion
- g. Piedmont Geriatric Hospital – Burkeville
- h. Catawba Hospital – Catawba
- i. *Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)*

CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DMHMRSAS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DMHMRSAS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M1550.300 MEDICAID TECHNICIANS

The Medicaid Technicians share responsibilities for the DMHMRSAS facilities assigned to their caseloads. See M1550, Appendix 1, for the chart listing the Medicaid Technicians, their supervisor, addresses, telephone numbers and caseload assignment.

M1550.400 CASE HANDLING PROCEDURES

A. Introduction

Effective July, 1994, the *Aged, Blind or Disabled (ABD)* Medicaid cases handled by local departments of social services and cases of patients in DMHMRSAS facilities will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a DMHMRSAS facility or leaves the DMHMRSAS facility to live in a community. Case transfer policy in M1520.600 is applicable.

NOTE: Transfer procedures are applicable *only* to individuals who are eligible in an ABD *covered group*. The Medicaid case of a child eligible in a Families and Children (F&C) *covered group* who is a patient in a DMHMRSAS facility is the responsibility of the local department of social services (LDSS) in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the LDSS in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

B. Procedures

Use *the policy and procedures contained in the subchapters below when an individual is:*

- admitted to a DMHMRSAS facility (M1550.401),
- *discharged from a DMHMRSAS facility to a community living arrangement* (M1550.402),
- *discharged from a DMHMRSAS facility to an assisted living facility (ALF) (M1550.403), and*
- discharged from a DMHMRSAS facility to a nursing facility or Medicaid Community-based Care (CBC) waiver services (M1550.404).

M1550.401 ADMISSION TO DMHMRSAS FACILITIES

A. Introduction

When a Medicaid recipient is admitted to a DMHMRSAS facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient

B. Local Social Services

1. ABD Recipient

When an ABD recipient has been admitted to a DMHMRSAS facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

If the recipient is not in the DMHMRSAS facility for 30 days, the local EW must complete the DMAS-122 for the patient's stay in the facility, and must send it to the facility's Reimbursement office.

After the ABD recipient has been in the facility for 30 days, transfer the Case to the appropriate Medicaid Technician in the appropriate DMHMRSAS facility. **Do not close the case.**

**2. F&C
Recipient**

IF the patient being admitted is an individual eligible in a Families and Children (F&C) category, the case will NOT be transferred to the DMHMRSAS facility, but will be retained by the LDSS. The individual will be considered temporarily absent from the home and will continue to be eligible in the F&C category as long as all non-financial and financial requirements are met.

**C. DMHMRSAS
Reimbursement
Office**

Send a DMAS-122 to the Medicaid Technician to advise of name of the patient, date of admission, facility, etc. The technician will take the following steps.

**1. Inquire
MEDPEND**

The Technician will inquire through MEDPEND and *Medicaid Management and Information System (MMIS)* to see if the patient has a pending Medicaid application or is *enrolled in* Medicaid. If a pending case is found in MEDPEND and the Medicaid Technician has not received the case, the Medicaid Technician will contact the eligibility worker (EW) in the LDSS which holds the patient's case and advise the EW that the recipient has been admitted to the facility. Pending applications must have eligibility determined with 45-90 days as per policy. The Medicaid Technician will request that the case be transferred immediately.

**2. Active Case
Found**

If inquiry into *MMIS* indicates an active Medicaid case and the Medicaid Technician has not received the case, the Medicaid Technician will contact Medical Records at the end of 30 days to determine if the patient is still in the facility.

- If the patient is still in the facility, the Medicaid Technician will request that the case be transferred.
- If the patient has left the facility before the end of the 30 day period, the Medicaid Technician will advise the EW in the local agency that the individual has left the facility. Reimbursement will send the DMAS-122 to the local EW for completion.

**3. No Active
Case Found**

If the patient has neither a pending application nor an active Medicaid case and Medicaid eligibility needs to be pursued, Reimbursement must submit a completed Application For Benefits on behalf of the patient, providing as much information as possible. Attach any verifications available and send to the Medicaid Technician.

**D. Medicaid
Technician**

When a DMAS-122 is received from Reimbursement, search MEDPEND and *MMIS* systems. NOTE: If the patient is between the ages of 21 and 65 and in an IMD, he or she cannot be Medicaid eligible while in the IMD. For other patients admitted, including those admitted as respite or emergency admissions, use the following procedures:

- 1. Pending Case in MEDPEND**

If a pending case is found in MEDPEND, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notification of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.
- 2. Active Case in MMIS**

If an active case is found in *MMIS*, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

 - a. If so, ask the EW in the *LDSS* holding the case to transfer the case.
 - b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-122 to Reimbursement indicating that patient must be determined by the local agency because the patient was not in the facility for 30 days.
- 3. Transfer Case Received**

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update *the MMIS* and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.
- 4. No Pending or Active Case**

If neither a pending application nor an active Medicaid case is found, open a case using a completed Application *for Benefits* submitted by the Reimbursement Office on behalf of the patient.

 - a. If a case number is found in MEDPEND or *MMIS*, use that case number to establish the hospital case.
 - b. If no case number is found in MEDPEND or *MMIS*, but there is an inactive case in the facility, use the facility case number.
 - c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.
- 5. Patient Discharged**

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

M1550.402 PATIENTS DISCHARGED FROM DMHMRSAS FACILITIES

A. Introduction

When a Medicaid *recipient* in a DMHMRSAS facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an *assisted living facility (ALF)*, see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. DMHMRSAS Discharge Planner/Social Worker/ Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an *assisted living facility (ALF)* or nursing facility will be transferred to the *LDSS* in which he or she will be living.

C. Reimbursement Office

Send the DMAS-122 to the Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of a Medicaid enrollee discharged to a living arrangement which is not an *ALF* or nursing facility will be transferred to the *LDSS in the locality where* he or she will be living.

Do a desk review of all cases to be transferred to an *LDSS*, **but do NOT determine if the recipient will be eligible in the locality.**

Update *the MMIS*. Enter the new city/county code *on the case*, new address, and change worker number to M0000.

Forward *the case* containing all original Medicaid information, any verification provided by discharge planner *and/or* Reimbursement office, and *the DMAS-122*, via certified mail to the appropriate *LDSS*.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send *the Case Record Transfer Form* to *the Medicaid Technician* to notify *the Technician* of disposition of *the transfer*.

M1550.403 PATIENTS DISCHARGED TO ALF

A. Introduction

When a patient in a DMHMRSAS facility will be discharged to an *assisted living facility (ALF)*, follow the procedures in this section.

B. DMHMRSAS Discharge Planner/Social Worker/ Reimbursement

The Medicaid case of a patient who will be discharged to enter an *ALF* will be transferred to the *LDSS* in the Virginia locality in which *the Medicaid recipient* last resided outside of an institution.

1. Medicaid Patient Discharge to ALF

For patients being discharged to an *ALF* who are Medicaid eligible in the DMHMRSAS facility, complete an Application For Benefits to apply for Auxiliary Grants (AG) and a Uniform Assessment Instrument. Attach copies of any verifications, a copy of the Community Placement Plan, the DMAS-122 and the DMAS-96. Send *the completed forms* to the *LDSS* immediately.

The Discharge Planner should not request information from the Medicaid case, but should complete the Application For Benefits providing the latest information available on the patient. The Medicaid Technician should also be given a copy of the Community Placement Plan and the DMAS-122 for the Medicaid case.

The Medicaid Technician will transfer the Medicaid case to the *LDSS*. However, the AG application form should be sent immediately to the appropriate *LDSS* in order to expedite processing, with a note that the patient's Medicaid case is being transferred to them. **The application must be received by the LDSS in the month of the patient's entry to the ALF in order for an AG payment to be made for that month, if eligible; no retroactive payments are made for AG.**

2. Patient Not On Medicaid, Discharged to ALF

For patients being discharged to an *ALF* who are not Medicaid eligible in the DMHMRSAS facility, but for whom a AG/Medicaid application needs to be pursued, complete an Application For Benefits providing the latest known information on the patient, and a *UAI*. Attach copies of any verifications available, a copy of the Community Placement Plan, the DMAS-122 and the DMAS-96.

Applications for patients being discharged to an *ALF* must be sent to the *LDSS* in the locality in which the patient last resided prior to entering the DMHMRSAS facility. If admission to the DMHMRSAS facility was from the out of state but the patient intends to remain in Virginia, the application must be sent to the *LDSS in the Virginia locality* in which the *ALF* is located. **Do not send any information to the Medicaid Technician located in the DMHMRSAS facility.**

The application must be received by the LDSS in the month of the patient's entry to the ALF in order for payment to be made for that month, if eligible; there are no retroactive payments made for AG.

**C. Medicaid
Technician**

Do a desk review of all cases to be transferred to a *LDSS*, **but do NOT determine if case will be eligible in the locality**. Update *the MMIS*. Enter new city/county code, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-122, via certified mail to the appropriate *LDSS*.

**D. Eligibility Worker
in LDSS**

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send *the Case Record Transfer Form* to *the Medicaid Technician* to notify *the Technician* that *the case was received by the agency*.

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a DMHMRSAS facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

**B. DMHMRSAS
Discharge Planner/
Social Worker/
Reimbursement**

**1. Patient Not On
Medicaid**

If the patient was not Medicaid-eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient *or* the patient's authorized representative may complete an Application For Benefits and send it to the appropriate *LDSS*.

Applicants for patients being discharged to a nursing facility must be sent to the *LDSS* in the locality in which the patient last resided prior to entering the DMHMRSAS facility. If admission to the DMHMRSAS facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

2. Medicaid Patient

If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-122 and any other information necessary to transfer the Medicaid case record.

C. Reimbursement Office

Send *the DMAS-122* to *the Medicaid Technician* and DMAS to advise them of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of an eligible individual discharged to a nursing facility or CBC will be transferred to the LDSS in the locality in which he or she last resided outside of an institution.

Do a desk review of the case to be transferred to the LDSS. Update the MMIS with the new city/county code, new address, and change the worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by the discharge planner and/or Reimbursement office, and the DMAS-122, via certified mail to the appropriate LDSS. Note on the Case Transfer Form that this case is a nursing facility or CBC waiver case so that the receiving agency will be alerted to take immediate action.

**E. Eligibility Worker in
LDSS**

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form copy to the Medicaid Technician to notify the Technician that the case was received by the agency.

***DMHMRSAS Facilities
Medicaid Technicians***

NAME	LOCATION	WORK TELEPHONE	CASELOAD
<i>Brenda Wolhfert, Supervisor</i>	<i>Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505</i>	<i>434-947-2754 cell 434-906- 0024</i>	<i>CVTC-caseload-A-H</i>
<i>Mary Lou Spiggle</i>	<i>Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505</i>	<i>434-947-6256</i>	<i>CVTC-caseload-I-Z PGH-caseload-H-Z WSH-caseload-all</i>
<i>Janet Benton</i>	<i>Central State Hospital Medicaid Office P. O. Box 4030 Petersburg, VA 23803</i>	<i>804-524-7582</i>	<i>SSVTC-caseload-all Hiram-Davis- caseload-all</i>
<i>Debra J. Quesenberry</i>	<i>Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070</i>	<i>540-375-4350 or 800-828-5158</i>	<i>Catawba-caseload-all PGH-caseload-A-G NVTC-caseload-all</i>
<i>Frances Jones</i>	<i>Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354</i>	<i>276-783-0841</i>	<i>SWVTC-caseload-all ESH-caseload-A-J</i>
<i>Terri Neel-Kinder</i>	<i>Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354</i>	<i>276-783-0842</i>	<i>SEVTC-caseload-all ESH-caseload-K-Z SWVMHI-caseload- all</i>

NOTE: *Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.*

DMHMRSAS Facilities:

CVTC – Central Virginia Training Center

ESH – Eastern State Hospital

NVTC – Northern Virginia Training Center

PGH – Piedmont Geriatric Hospital

SEVTC – Southeastern Virginia Training Center

SSVTC – Southside Virginia Training Center

SWVMHI – Southwestern Virginia Mental Health Institute

SWVTC – Southwestern Virginia Training Center

WSH – Western State Hospital

**1. Provider
Enrollment**

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE**A. General
Information**

Most Virginia Medicaid recipients are required to receive medical care through a managed care program. There are two managed care programs that operate simultaneously within the Commonwealth: The MEDALLION Program, a Primary Care Case Management program, and Medallion II, a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid recipients. Both programs require recipients to choose a primary care provider (PCP) who provides primary health care services and makes referrals as needed. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

**B. Recipients
Exempt from
Managed Care****General**

The following recipients are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Foster Care (including Treatment Foster Care), Adoption Assistance, and Residential Treatment Facility programs;
- inpatients in State mental hospitals, including but not limited to:
 - Central State Hospital,
 - Eastern State Hospital,
 - Western State Hospital,
 - Hiram W. Davis Medical Center,
 - Northern Virginia Mental Health Institute,
 - Southern Virginia Mental Health Institute,
 - Southwestern Virginia Mental Health Institute, and
 - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center).
- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR), and recipients approved for Medicaid community-based care waiver services;

- Qualified Medicare Beneficiaries (QMB), dually-eligible recipients, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);
- recipients with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program;
- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;
- women enrolled in the Family Planning Services (FPS) covered group;
- recipients who receive hospice services in accordance with DMAS criteria;
- refugees; and
- recipients on a spenddown.

MEDALLION

The following recipients are excluded from participating in MEDALLION:

- recipients who are not accepted to the caseload of any participating PCP, and
- recipients whose enrollment in the caseload of the assigned PCP has been terminated and whose enrollment has been declined by other PCPs.

Medallion II

The following recipients are excluded from participating in Medallion II:

- recipients, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those placed there for medically necessary services funded by the MCO;

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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);

- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

- a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:
 - refugees or *Cuban-Haitian Entrants* (see M0220.310 A. 2 and 7),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52)
- b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens, *other than Cuban-Haitian Entrants*, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

Appendix 4, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

4. HIPP Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.

D. FAMIS Nonfinancial Requirements The child must meet the following FAMIS nonfinancial requirements:

1. Age Requirement The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

2. Uninsured Child The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

3. State Employee Prohibition A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.

4. IMD Prohibition The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, *or the child is pregnant*.

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, *or whether the discontinuance of health insurance affects the child's eligibility*, family member means:

- parent(s) *with whom the child is living*, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- “any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.

Health benefit plan does not mean:

- Medicare, Medicaid, State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;

The parent, legal guardian, authorized representative, an adult relative with whom the child lives, *or the child if age 18*, must sign the application. The adult relative must be related by blood or marriage. *Accept declaration of relationship*; documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

**B. Eligibility
Determination**

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. The applicant/*enrollee* must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS or the FAMIS CPU. Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

**C. Entitlement and
Enrollment**

Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth. There is no retroactive coverage in the FAMIS program.**

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

Because Medicaid and FAMIS are separate programs, Medicaid eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in Medicaid in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V000 to transfer the case to the FAMIS CPU. The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

**D. Notification
Requirements**

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 *calendar* days, the original application date will be honored.

**E. FAMIS Case
Transfer Procedures**

Individuals approved for FAMIS are enrolled in MMIS by the LDSS and then transferred to the FAMIS CPU by changing the worker number to "V0000." If a family has at least one child who is Medicaid-eligible and at least one child who is FAMIS-eligible, the Medicaid case remains at the LDSS and a separate FAMIS case is created in MMIS via the ADAPT "Medicaid Authorization" (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS.

The worker sends the FAMIS-related case material to the FAMIS CPU via the courier by the end of the business day following the eligibility determination so the managed care assignment can be initiated. The LDSS retains the original application, verifications, and the notice and has responsibility for ongoing case maintenance of the Medicaid case.

**1. Case Material
Sent to CPU**

The documentation necessary for a case transfer to the FAMIS CPU has been modified. To allow the FAMIS CPU to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the following documents:

- a. The ADAPT Statement of Facts (SOF). The SOF does not need to be signed. If the case is not in ADAPT, send a copy of the most recent application form. If transferring a case after a renewal, send a copy of the most recent completed application form plus the most recent renewal form. The CPU cannot accept the Medicaid Renewal Form by itself because it does not contain all the demographic information necessary to enter the family into the CPU's computer system.*
- b. For an ADAPT case, print copies of the ADAPT income detail screens from the Application Entry Income Eligibility submenu for each family member who has income. The CPU needs to know the source of the income, the employer's name (if the income is earned), the amount of income received each time it is paid to the individual, and the frequency of the income. This information is on the income detail screen; it is not on any wrap-up screen.*

If the case is not in ADAPT, include a copy of a written eligibility evaluation form that has the income source details (source name, employer name, date(s) the income was received, frequency, and the eligibility calculations).

- c. *Copies of the appropriate ADAPT Medicaid Wrap-up screen(s):*
- *“MC F&C FAMIS Family Unit Income Test” (AEXXIU) for FAMIS children.*
 - *“MC MI & FAMIS PG Family Unit Income Test” (AEMCFU) screen, and “MC MI & FAMIS PG Budget Unit Income Test” (AEMCAU) screen if budget units were formed, for FAMIS MOMS-enrolled pregnant women.*

If the case is not in ADAPT, include a copy of a written eligibility evaluation form in place of these ADAPT wrap-up screen prints.

- d. *Income verifications if any individual in the assistance unit has income.*
- e. *A copy of the ADAPT Notice of Action (NOA), or a copy of the written NOA, that was sent to the applicant about the FAMIS or FAMIS MOMS eligibility.*
- f. *A completed Case Record Transfer sheet.*

Additional case information that is not used to determine FAMIS eligibility should not be sent to the CPU.

2. Sending Case to the CPU

When transferring a case, confidentiality must be ensured by placing the case documents in a sealed interdepartmental envelope that is addressed to the FAMIS CPU (FIPS 976) and sent via the courier no later than the business day following the FAMIS eligibility determination. This ensures timely receipt of the case by the CPU so that the managed care assignment can be initiated, and the eligible individuals can be sent a FAMIS eligibility confirmation “packet” of information about their managed care assignment and the amount of their co-pay for covered services.

If the case is mailed via the United States Postal Service’s certified mail, the envelope must contain the full mailing address of the FAMIS CPU:

*FAMIS CPU
P.O. Box 1820
Richmond, VA 23218-1820*

F. Transitions Between Medicaid And FAMIS (Changes and Renewals)

1. Actions Required

Transitions between Medicaid and FAMIS require cancellation of the current coverage and reinstatement in the new coverage, and may require

additional coordination between the LDSS and the FAMIS CPU. Certain MMIS transactions can only be done by the FAMIS CPU, the DMAS FAMIS Plus Unit or the LDSS. Only the FAMIS CPU can cancel FAMIS or FAMIS MOMS coverage when the case is in worker number V0000. Only the LDSS can cancel Medicaid coverage for cases that are active or connected to active cases in ADAPT or MMIS. The DMAS FAMIS Plus Unit can add or reinstate Medicaid coverage only on cases processed by the DMAS FAMIS Plus Unit. The LDSS is responsible for reinstating Medicaid coverage on cases processed by the LDSS and may cancel Medicaid coverage and reinstate FAMIS coverage.

**2. Case Transfer
When Program
Changes**

When eligibility transitions between Medicaid and FAMIS, there must be communication between the FAMIS CPU, the LDSS, and the applicant. The Case Record Transfer Form (#032-32-227) must be completed by the sender and attached to the case record. The sender must also notify the applicant of the case transfer. The receiver must confirm receipt of the case by completing the Case Record Transfer Form and returning it to the sender. The receiving agency is not required to complete a Medicaid redetermination until a change is reported or at the time of the next annual redetermination.

So that the FAMIS CPU will be able to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the documents listed in section M2140.100 E., above.

**G. Communicating
Changes to the CPU**

The Children's Health Insurance Communication Form (#032-03-630) is used by the LDSS to communicate changes to the FAMIS CPU on FAMIS and FAMIS MOMS cases. This form can be downloaded from the DSS intranet at:

<http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/general/032-03-0630-01-eng.doc>. The form is in Appendix 3 to this chapter.

The form must include the case name, the MMIS name and enrollee identification number, the reason for the communication, and all other relevant information. The FAMIS CPU must receive the Communication Form by the 10th calendar day of the month in order for the FAMIS/FAMIS MOMS cancellation to be effective by the end of the current month. If the form is received after the 10th calendar day of the month, the cancellation will be effective the last day of the following month.

**H. FAMIS CPU
Responsibilities and
Procedures**

Applications, redetermination applications (sent to a FAMIS recipient when a change is reported to the CPU), and renewals are faxed or mailed to the FAMIS CPU by applicants or recipients. Within three days of receipt, the CPU staff logs the application, redetermination or renewal into the FAMIS eligibility system. There are no drop-offs and no face-to-face contact with applicants or recipients at the CPU. All applications are scanned and linked for electronic data recovery.

If an application is complete when it arrives at the FAMIS CPU, it takes approximately 12 business days or less to process the case. In order for an application to be complete, it must be signed and must include all

required verifications. If the application is not complete when it is received, a “deficiency letter” is sent and the family is given 30 days to respond. In such cases, it can take more than 30 days to process the case. If the required verification is not received by the 30th day, the application is denied for failure to provide information, and the family is notified of the action.

When an application is approved for FAMIS or FAMIS MOMS, the FAMIS CPU initiates the managed care assignment and provides ongoing case maintenance. When an application is not Medicaid-likely and is not eligible for FAMIS or FAMIS MOMS, the CPU sends the denial or cancellation notice to the applicant. When an application is determined as Medicaid-likely, the application is sent over to the DMAS FAMIS Plus Unit for a Medicaid eligibility determination.

**I. DMAS FAMIS Plus
Unit Responsibilities
and Procedures**

Medicaid-likely applications referred to the DMAS FAMIS Plus Unit from the FAMIS CPU are recorded on a daily log. Steps are being taken to allow the DMAS FAMIS Plus Unit to build and transfer applications in ADAPT and MEDPEND. All referred applications are screened for Medicaid eligibility by the DMAS FAMIS Plus Unit. Medicaid-likely applications connected to active cases in ADAPT or MMIS are transferred to LDSS for processing, and notice of the transfer is sent to the family. The application, the verifications, and a copy of the notice are placed in a sealed envelope and transferred to the LDSS via the courier no later than the next business day.

The DMAS FAMIS Plus Unit processes Medicaid-likely applications that have been pending 25 days or more, and transfers enrolled Medicaid cases to the LDSS. If the unit’s screening determines that the application is not Medicaid-likely, then a FAMIS eligibility determination is completed and the case is returned to the FAMIS CPU in an approved or denied status.

FAMIS redeterminations and renewals are also screened for Medicaid eligibility and, if Medicaid-likely, are referred to the DMAS FAMIS Plus Unit. If the Medicaid-likely FAMIS redetermination or renewal is connected to an active case in ADAPT or MMIS, the case is transferred to the LDSS for the Medicaid determination. If the Medicaid-likely FAMIS redetermination/renewal is not connected to an active case, the DMAS FAMIS Plus Unit completes the Medicaid determination and transfers the approved ongoing case to the LDSS.

**J. DMAS Contacts at
the CPU**

The DMAS FAMIS Plus Unit eligibility workers are designated as the liaisons between the LDSS workers and the FAMIS CPU staff. The FAMIS Plus Unit workers are assigned to specific geographic areas. These assignments were made to improve communication and facilitate resolution to problems involving cases that have been transferred between the CPU and LDSS. The DMAS FAMIS Plus workers are assigned to five geographic areas of the state. The geographic areas correspond to the former LDSS regions. The list of the DMAS FAMIS Plus workers and the areas they serve is available on the DSS intranet in the Benefit Programs, Medicaid Eligibility, ME Contacts folder.

The DMAS FAMIS Plus workers will:

- *act as contact persons for cases transferred to the CPU and the LDSS,*
- *answer non-policy related questions regarding transferring or closing cases, and*
- *change worker number V0000 to M0000 when necessary.*

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medicaid Consultant for assistance with policy clarifications, computer system problems, and client complaints.

*Please note that the DMAS FAMIS Plus workers' telephone numbers are for the LDSS workers only and **are not to be given to clients**. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is **not** for use by LDSS workers.*

K. FAMIS Select

Under the FAMIS program, a family who has access to health insurance through an employer, or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

L. 12-Month Continuous Coverage

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

NOTE: The ADAPT NOA meets the notification requirements. When a NOA is generated by ADAPT, do not send the NOA form #032-03-008.

**F. Transfer Case to
FAMIS CPU**

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

See chapter M21, section M2140.100 E for the procedures to use when transferring a FAMIS MOMS case to the FAMIS CPU.

**G. Transitions Between
Medicaid And FAMIS
MOMS (Changes and
Renewals)**

See chapter M21, sections M2140.100 F through J for the procedures to use when an enrollee transitions between Medicaid and FAMIS MOMS.

**H. Application
Required for
Newborn**

The newborn child born to a FAMIS MOMS enrollee is NOT deemed eligible for FAMIS or Medicaid. The newborn's parent, guardian or authorized representative must file an application for medical assistance for the newborn to have the newborn's eligibility determined for Medicaid and/or FAMIS.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.